Maternal and Child Health Services
Title V Block Grant

State Narrative for Tennessee

Application for 2009
Annual Report for 2007

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and Certifications may be obtained from the Tennessee Department of Health, Maternal and Child Health Section, located at 425 5th Avenue, North, 5th Floor, Cordell Hull Building, Nashville, TN 37243.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

MCH continued its history of holding public meetings in collaboration with the WIC program regarding its role and services offered at the county level. A letter and fact sheet about both programs were sent to over 500 agencies and health care providers, and all physician members of the Tennessee Medical Association and the Tennessee Hospital Association announcing the location and time of the public hearings. Three public hearings were held across the state in June 2008 in conjunction with the WIC program staff. The information was released to the press, and the information was placed on the Department's web site. Any findings will be addressed.

In addition, each Regional Health Council receives a copy of the Block Grant through the regional director for review and comment. Written comments will be reviewed and included with the next Block Grant submittal.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

In application year 2009, it is recommended that only IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

A. Overview

While Tennessee has enjoyed some favorable economic trends in the past, May 2007 data show a 5.0 percent non-seasonally adjusted unemployment rate statewide as compared to 4.6 percent nationally. This trend is a slight decrease over year's data for the state (5.4 percent). The state has a diverse market economy, a fairly large population of skilled laborers, low state taxes, and no personal income tax, which helps to attract business and industry. However, this has been superimposed on a background of dwindling federal aid, transference of jobs out of the country, the loss of manufacturing jobs and business revenue, high taxes on food, and increasing local taxes. The State continues to struggle with balancing its budget. Inner-city urban areas, small rural areas and unique areas such as those in the Appalachian Mountains continue to experience increasing poverty.

/2009/ The May 2008 data (2006 American Community Survey) show 4.6 percent non-seasonally adjusted unemployment rate statewide as compared to 4.14 percent nationally.// 2009//.

Geography: Tennessee is a diverse state which covers 41,220 square miles of land area and is approximately 500 miles from east to west and 110 miles from north to south. The state is divided into 95 counties, each with a health department mandated by state law and located in the county seat. For departmental administrative purposes, the counties are grouped into seven rural and six metropolitan health regions.

Topographically, as well as culturally and economically, the state is divided into three grand regions. East Tennessee is a 35 county area, containing the Appalachian Mountains and bordered by Virginia, Kentucky, North Carolina, and Georgia. This region contains Knoxville and Chattanooga, the third and fourth largest cities, respectively. Johnson City, with a population over 50,000, is located in the extreme upper East end of the region and is the location of East Tennessee State University (ETSU) and the Quillen-Dishner School of Medicine. The ETSU Genetic Center provides on-going treatment and patient education after cases are confirmed by the Genetic Metabolic Centers. Erlanger Hospital in Chattanooga provides similar services after cases are confirmed. The University of Tennessee-Knoxville School of Medicine is one of the state's three Genetic Metabolic Centers, providing confirmatory diagnosis for suspected cases in the larger genetic region and treatment for those cases in the specific geographic area. These same medical sites also serve as the regional perinatal center sites. The East Tennessee region is home to ten nursing schools to help address the critical nursing shortage that faces our nation and public health infrastructure.

Middle Tennessee encompasses 39 counties and is bordered by Kentucky and Alabama. The topography ranges from mountains in the east to the Tennessee River on the western edge. Nashville, the capital of the state, and second largest city, as well as two other cities with populations over 50,000 are located in this region: Clarksville, home to the Fort Campbell military base; and Murfreesboro, one of the fastest growing cities in the state and home of Middle Tennessee State University. The Middle Tennessee region houses two of the country's oldest and most prestigious medical schools, Meharry Medical School and Vanderbilt School of Medicine; both provide program services. Meharry confirms all diagnoses of sickle cell anemia for suspected cases in the state and serves as the Middle Tennessee Regional Sickle Cell Center. Vanderbilt serves as the regional perinatal center and as another of the three Genetic Metabolic Centers confirming diagnoses for the larger region and providing treatment for cases in their specific catchment area. In addition, Vanderbilt houses one of the nation's noted Schools of Nursing which assists in

developing the latest nursing curricula and produces top community program models. In addition, the middle region houses eleven more schools of nursing which assist in replenishing the retiring public health nursing infrastructure.

The western part of the state has 21 counties and is bordered by the Mississippi and Tennessee Rivers and the states of Mississippi, Missouri, Kentucky and Arkansas. This area is part of the Delta, or Gulf Coastal Plain, and is very flat, rural and sparsely populated, with the exception of Memphis, the state's largest city, and Jackson. The University of Tennessee/Memphis Medical School is the third Genetic Metabolic Center confirming diagnoses for the West Tennessee area and providing treatment for cases in its catchment area through the Boling Center for Developmental Disabilities -- an affiliate of the Medical School's Pediatric Department. This site also serves as the perinatal center for the western part of the state. Western Tennessee has ten nursing schools to address the growing infrastructure need.

Population Changes: Using the latest federal census figures, Tennessee's 2006 population was 6,038,636, which puts the state at 16th in the nation in total population. By 2010, Tennessee is projected to have a population of 6,264,654. During the 1990-95 period, Tennessee's population growth surpassed the increase experienced during the entire decade of the 1980's and outpaced the national average growth rate. During the 1990-99 period, Tennessee was the fourth fastest growing state in the Southeast. The distribution of Tennessee's population by race and sex has not changed significantly in the past several years: For people reporting only one race, 17 percent were black, 81 percent were white, less than 0.5 percent were American Indian and Alaska Native, less than 0.5 percent were Native Hawaiian and Other Pacific Islander, 1 percent were Asian, and 1 percent were some other races. Tennessee's population is 49 percent male and 51 percent female.

Tennessee is expected to gain 97,000 people through international migration between 1995 and 2025 and is expected to gain 845,000 people through internal migration for the same time period. The population over age 18 is expected to grow from 3.9 million to 5.2 million in 2025 while those classified as youth (under 20 years old) will decline from 27.7 percent in 1995 to 23.8 percent in 2025. The elderly population is expected to accelerate rapidly. All ethnic and racial groups are expected to increase during this time period except for non-Hispanic whites. African Americans, Asians, and persons of Hispanic origin will experience the greatest gain.

In 2005, 24 percent of Tennesseans were under the age of eighteen. Females aged 10-44 make up 24.7 percent of the total population. This reproductive age female population peaks within the 35-44 age group. The two largest population groups are reproductive age women and children under 18 -- the target population served by MCH. This has implications for outreach and recruitment efforts as well as for types of services offered.

Continuing the trend established in the mid-1980s, Middle Tennessee counties led the state's recent growth, with an average increase of 16.5 percent between 1990 and 1998. East Tennessee counties were next, with 6.9 percent growth, followed by the West Tennessee counties, which experienced a 5 percent net increase. Metropolitan counties (defined as those within a Metropolitan Statistical Area [MSA]) grew an average of 11.5 percent between 1990 and 1998.

Slightly more than a quarter of all Tennesseans live in the four largest cities. Just over 68 percent of Tennessee's population resides in the state's seven MSAs, five of which are in the eastern two-thirds of the state. The most sparsely populated counties are primarily in rural Middle and West Tennessee.

Ethnicity: Less than three percent of the people living in Tennessee in 2000 were foreign born, although the state has experienced a 169 percent increase from 1990. Of the foreign-

born population, approximately 40 percent are of Latin American origin, and almost a third is of Asian origin. Hispanics are the largest ethnic minority in Tennessee. According to the 2000 Census, 123,838 persons, or 2.2 percent of all Tennesseans, identified themselves as being of Hispanic origin. In 2005, the Hispanic population is estimated at 3.0 percent, 172,704 persons. The actual number is most likely larger than the reported number due to the growing population of migrant workers and undocumented residents across the state.

Tennessee has a wide variety of ethnic groups in addition to Hispanics. Southeast Asians are the second largest group (72,031) and the state is the fifth largest Kurdish resettlement site in the country. Refugees and legal immigrants have also been arriving from African, Baltic, Central Asian, and Southeast Asian countries. Among people at least five years old living in Tennessee in 2005, 6 percent spoke a language other than English at home. Of those, 55 percent spoke Spanish and 45 percent spoke some other language. According to the Tennessee Foreign Language Institute, there are over 169 different languages currently being spoken in Tennessee.

Tennessee's immigrant and refugee population is concentrated in the Nashville area (50-60 percent), in Memphis (30 percent) and in the rural agricultural-based counties in the southeastern and western parts of the state.

These new arrivals face access to care issues: obtaining health insurance is a critical barrier to care. In addition, they may have chronic, difficult to treat health problems that are unfamiliar to health care providers. The language barrier is a very real obstacle to care, as is the mix of cultures with which providers are equally unfamiliar. The cultural factor has a special impact on maternal and child health service delivery. In addition, both the 2006 and 2007 legislative sessions had several pieces of legislation, although they failed to pass, which threatened to cut some of the basic services offered by any State agency for this growing population. These trends make it imperative for the Department to consider the health issues and implications of caring for this growing population.

Poverty Level: Tennessee figures from the 2005 American Community Survey Profile (U.S. Census Bureau) show 16.0 percent of Tennesseans live in poverty compared to 13.3 percent nationally. 21.4 percent of Tennesseans under age 18 live in poverty compared to 18.4 percent nationally. 12.5 percent of all families and 33.7 percent of families with a female head of household and no husband present had incomes below the poverty level. 10 percent of the population in Tennessee received food stamp benefits within the past 12 months compared to 6.7 percent nationally.

According to the 2006 Kids Count Data Book, in 2004, 21 percent of Tennessee's children under 18 were in poverty, compared to 18 percent for the United States. Tennessee ranked 36th in the nation on this measure, up from 34th in 2001. Ten percent of children were in extreme poverty (below 50 percent poverty), compared to 8 percent for the nation. 21 percent percent of children were without health insurance, compared to 12 percent nationally. While overall poverty rates in the state and in the South have been falling, the condition of Tennessee's children is still a major cause for concern.

/2009/ In the 2007 KIDS COUNT Data Book, in 2005, 20 percent of Tennessee's children under 18 were impoverished, compared to 19 percent nationally. Tennessee retained its 36th rank. Ten percent of children remained in extreme poverty. Ten percent of children were without health insurance compared to 11 percent nationally.//2009//.

Income: Tennessee's median household income in 2004 was $38,874, which is 8.4 percent below that of the U.S. ($46,242). Tennessee's annual average rate has been below the national average since 1989 indicating that while most Tennesseans are employed, salaried and hourly employees make less on average than persons in other states. The 2005 national average per capita income was $25,035; Tennessee's for the same year was $22,090. Tennessee ranks 36th

in the U.S. on this measure (University of Tennessee, Center for Business and Economic Research).

Households and Families: Of the total number of Tennessee households in 2005, 68 percent were families, mostly married-couple families. Thirteen percent were headed by single women. The recently added measure of grandparents as caregivers showed 134,157 (up from 113,247 in 2001) as having responsibility for their grandchildren under the age of 18. As in most other states, about half of the grandparents who live with their grandchildren are responsible for them. Of these grandparents, 19.2 percent live in poverty.

Health Statistics Data: As in the nation and in the other southeastern states, Tennessee rates for adolescent pregnancy have been on the decline. In 2003-04, Tennessee mirrored the nation by showing a slight rise in infant mortality. Memphis, the largest city in the state and located in the West Tennessee region, was recently noted to have the worst infant mortality rate in the nation for a major metropolitan area. In 2005, Tennessee was ranked 48th compared to other states. Low birthweight (LBW), which is a major risk factor for adverse health outcomes for both infants and children, increased in recent years and was 8.2 percent in 2005. Between 1994-2004, LBW increased 7 percent compared to nation's 11 percent increase during the same period. Additionally, the African American low birthweight rate for 2005 was 15.3 percent, 1.9 times greater than the white LBW rate of 8.2 percent. This gap has been evident for many years and continues despite the increasing availability of services targeted to these populations. The LBW rate for Hispanic babies is 6.2 and did not significantly change between 1994-2004. Another major concern is the disparity in the pregnancy outcomes for the African American and white populations. In 2005, the infant mortality rate for births to African American women in Tennessee was 2.7 times greater than the rate for births to white women. Data for 2003 for adolescent pregnancy (ages 10-17) show the lowest rate recorded since 1975. In 2005 this decreasing trend continued; the adolescent pregnancy rate for this age group was 13.3 percent. The rate dropped for both the white and the African American populations; however, the gap between the two groups remains. For 2005, the rate of adolescent pregnancy for the African American population was 2.3 times that for the white population. These data show that the MCH programs and services in Tennessee continue to be of great need and that resources must continue to be targeted to address the major disparities. In addition, the dismal rates show the need for more comprehensive data collection and analysis to assist in developing strategies to improve the pregnancy outcomes of the youngest Tennesseans.

Data trends on diseases: Disease trends for sexually transmitted diseases (STD) show that Tennessee has experienced a dramatic reduction in STD morbidity, with the exception of chlamydia, over the past five years. The rise in chlamydia morbidity has been due to additional screening within the family planning and STD clinics statewide. Like other STDs, syphilis is reported mostly from the large metropolitan areas. The six metropolitan counties represent approximately 42 percent of the State's population and reported 82 percent of the 779 cases of early syphilis cases in 2004. Nashville and Memphis reported 80 percent of the state's total cases. The 2004 data (1,159) show a significant decrease in cases since 2000.

The number of gonorrhea cases has declined from a record high rate of 817/100,000 in 1976 to 145.1/100,000 in 2004. This rate compares to 169/100,000 in 2002. The metropolitan counties have consistently accounted for 75-85 percent of the state's morbidity.

In 1995, state funding was made available for chlamydia testing in STD and Family Planning clinics. As a result, 13,152 cases were reported in 1995, a 94 percent increase over 1994. The overall statewide screening positivity rate for chlamydia increased from 7 percent in 2002 to 10.9 percent in 2004. 22,515 cases were reported in 2004. Of these cases, 72.1 percent occurred in females, reflecting the fact that most chlamydia tests are performed on women visiting health department STD, family planning and prenatal clinics. Black females aged 15-19 have the highest rate of infection. In 2004, 87 percent of chlamydia morbidity occurred among patients aged 15-29. Rural regions had positivity rates ranging from 5-11 percent, and the metropolitan areas ranged

from 8-21 percent.

Targeted services to decrease syphilis continue in Nashville and Memphis. Counties with the highest overall STD rates are in the western part of the state, which has a high percentage of minority residents. The Department continues to place significant emphasis on STD screening, outreach, and treatment, including chlamydia, gonorrhea, and syphilis, with clinic services available in all counties and targeted outreach in the larger metropolitan counties.

Health Disparity: The confounding issues of race and poverty contribute to some of the more serious health problems and health status indicators in the state. The following is a summary of significant issues the Tennessee Department of Health (TDH) is addressing through local health department services and state health initiatives focused on women, infants and children.

African-American adolescents have a disproportionately higher pregnancy rate than white adolescents in all age groups -- a fact being addressed through the state's Adolescent Pregnancy Prevention Program, the Abstinence Only Education Program, general health education, family planning clinics and EPSDT screenings offered through the local health departments.

A higher number of minority women are likely to enter prenatal care after the first trimester of pregnancy --which is being addressed through TennCare enrollment of pregnant women, home visiting services, public-private partnerships and pregnancy testing and referral available at all local health department sites. In addition, TennCare, Tennessee's Medicaid program, has begun to utilize HEDIS quality measures to determine effectiveness of managed care organizations.

The infant mortality rate for minorities in 2005 was over two and one half times that of whites. African-American births comprise 20 percent of the total births, but 40 percent of all infant deaths were African-American. Neonatal mortality rates are 2.12 times higher for African American infants than they are for white infants (11.5 vs. 5.4). Local health departments are using the Help Us Grow Successfully (HUGS) home visiting program for special outreach and follow-up for high-risk pregnancies and high-risk neonates.

Currently the HUGS Program offers home visiting and care coordination services in eighty-nine (89) Tennessee counties for pregnant women, postpartum women up to two years, women who have lost a child under the age of two years and children from birth through the age of five. A vital part of the program is the prevention and/or intervention services offered in the home setting because it provides an opportunity to gain greater understanding of the client's needs, constraints, and supports available in the home. Such services assist this population in gaining access to health care, psychosocial, educational, and other necessary services to promote good health practices, improve general well being, prevent developmental delays, and reduce maternal and/or infant morbidity and mortality. Homevisitors have been cross-trained by WIC peer breastfeeding counselors to offer initial help to mothers during their first few weeks at home. In addition, efforts are being made to train homevisitors to assess mothers for depression utilizing a standardized tool and to assist mothers in smoking cessation.

Because Sudden Infant Death Syndrome is the 3rd major cause of infant mortality in Tennessee, the state of Tennessee has created a program to help families reduce the risk of losing their babies to SIDS. The goal of the SIDS program is to reduce the number of SIDS deaths, and to provide bereavement support for families who have experienced the sudden, unexpected death of an infant. The program is designed to target several objectives focused on protecting Tennessee's infants from SIDS. One way to learn more about SIDS is to study information gathered from autopsies. The program is working to make autopsies available for every suspected SIDS death. Another objective is to maintain a system of collecting data that will help create a picture of the SIDS infant and family in Tennessee. A third objective is to provide support to families through published materials and home visits by public health professionals, as well as referrals for counseling, and support groups for families who have experienced the tragedy of SIDS. The Tennessee SIDS program is also dedicated to educating professionals,

parents, community agencies, clergy, law enforcement personnel, emergency responders and all other interested persons who may encounter SIDS deaths throughout the state.

During the 2006 National Public Health Week, the Department of Health launched a statewide campaign to raise awareness of the State's horrific infant mortality rate. A logo and website were created. The logo has been utilized on several local media and public awareness projects that are presently being implemented.

High infant mortality rates are amplified in the western part of the state and include Memphis. The racial disparity is also worse in this geographic region. A summit of stakeholders representing community agencies, healthcare organizations and private providers, faith-based institutions, and the business entities was convened in Memphis in 2006. Governor Bredesen and the Shelby County local health department and government (location of Memphis) co-hosted the meeting. Governor Bredesen authorized the establishment of a statewide Fetal Infant Mortality Review, as well as a cabinet level coordination of statewide efforts to decrease infant mortality. Since 2006, he has authorized over 7 million dollars, a portion in recurring funds, to advance the efforts.

The local health department serves as a first point of contact for TennCare enrollment under presumptive eligibility for pregnant women. The Healthy Start Home Visiting Program targets first time, high-risk mothers with a special emphasis on teens who are parents. The Perinatal Regionalization system is an established, effective statewide service designed to provide expert consultation about problem pregnancies and to transport the mother and baby to the next level hospital when necessary to improve the health service available to the mother and/or infant. The Campaign for Healthier Babies in Memphis and West Tennessee continues as a strong population based approach, targeting women with media messages and coupon incentives promoting the importance of early prenatal care.

/2009/ Update on Infant Mortality efforts: The Governor's Office of Children Care Coordination (GOCCC) and the Department of Health continue leading efforts to decrease infant mortality in Tennessee. The GOCCC established three key stakeholder advisory boards and hired three coordinators, one for each of the state's grand divisions. Evidenced-based efforts were funded across the state to achieve a reduction in the infant mortality rate. Some of these efforts have been implemented and are demonstrating success; including Centering Pregnancy, tobacco cessation in pregnant women and a faith-based home visiting program. Fetal Infant Mortality Review was established by legislation and will be piloted in the urban Nashville and rural East Tennessee locations in the summer of 2008. The first year of the CDC's PRAMS survey data was completed April 30, 2008 and the State awaits analysis of the data. //2009//

The state's child fatality review system provides an additional data source for determination of need for action within the targeted populations. In 2004, Child Fatality Review Teams (CFRT) reviewed 1,042 (95.2 percent) of the 1,095 fatalities of Tennessee resident children under age 18 that occurred in 2004. Department of Health team leaders provided administration and coordination of the teams. The CFRT reviewed the way children died (Manner of Death) in Tennessee and what caused the deaths (Cause of Death). The manner of death for child fatalities in 2004 was determined by the CFRT to be: natural causes, 68.71 percent; unintentional injury (accidental) causes, 21.88 percent; homicide, 2.98 percent (down from 3.20 percent in 2003); suicide, 1.73 percent; could not determine, 3.55 percent; and undetermined due to suspicious circumstances, 1.15 percent.

The child fatalities were divided into the following categories by cause of death: non-injury, 68.62 percent; injury-related, 25.91 percent; other cause not listed, 2.78 percent; and unknown, 2.69 percent. The greatest number of deaths due to non-injury resulted from illness (N=335) followed by prematurity (N=311), both figures decreased from 2003. Of the deaths where gestational age was reported, 121 involved extremely premature infants (i.e., less than 23 weeks gestation), and

151 (down from 199 in 2003) involved gestations of 23 to 39 weeks. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents: 50 percent of all injury-related fatalities. Suffocation/strangulation fatalities were the next most common cause of injury-related death, 13.7 percent. For African-American children, injury-related deaths were nearly twice as likely as for white children and children from other races.

African-American children, more than white children, are diagnosed with elevated blood lead levels. The Childhood Lead Poisoning Prevention Program's purpose is to identify children with elevated blood lead levels and prevent childhood lead poisoning. Through extensive collaboration with public and private partners, the state has developed a program targeting areas of highest risk of childhood lead poisoning based on old housing, children in poverty, and number of low income housing units.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. By state law, there is a health department in every county; highly populated counties may have several health department sites. Title V has played an increasingly important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs (CSHCN).

The local health department is an integral part of the health care delivery system. In rural and urban counties, the local health department provides many TennCare services as a means of ensuring access to care for eligible citizens. The local health department has always provided information and referral services for county residents. Local health department nurses have provided screening and then enrollment for pregnant women presumptively eligible for TennCare.

In 1994, when the state's Medicaid managed care system (TennCare) was implemented, the Title V role changed once again but has not diminished in importance. Direct services in all traditional areas of public health are still provided and new roles developed, especially in relation to outreach and follow up with patients enrolled in TennCare. Title V service providers are flexible and responsive to the unique needs of county residents since the managed care system is so varied across the state. Public-private partnerships emerged to assure that health care needs are met.

In 2004, following a full year of study, the Governor proposed a comprehensive TennCare reform strategy designed to preserve full enrollment by placing reasonable limits on benefits. The plan garnered broad support from legislators, providers and enrollees, but public-interest lawyers thwarted it by refusing to lift legal roadblocks to reform.

As a result, in 2005 the State instead moved ahead with an alternate strategy to reduce benefits and enrollment for some adults while preserving full coverage for children. Even after reductions in adult enrollment to maintain fiscal balance, TennCare remains one of the most generous and comprehensive state healthcare plans. Moving forward, the State is pursuing a range of additional cost-containment strategies, including:

1) Requiring managed-care organizations (MCOs) to assume more financial risk in the delivery of TennCare benefits. The MCOs were relieved of financial risk in 2002 in an effort to stabilize the healthcare program. Restoring risk is critical to managing TennCare.
2) Increasing efforts to stamp out fraud and abuse. In 2004, Governor Bredesen launched the TennCare Office of the Inspector General to investigate civil and criminal fraud and abuse within the program. Since then, the State has opened investigations and brought charges against scores of individuals and organizations attempting to defraud taxpayers.
3) Working through the courts to challenge legal constraints. "Consent decrees" placed on the program by public-interest lawyers beginning in the 1990's obligate the State to provide benefits well beyond federal requirements and, among other things, prevent the State from placing reasonable limits on the use of prescription drugs.

4) Developing new care- and disease-management practices and making better use of health information technology (HIT). For example, the Governor's Volunteer eHealth Initiative is one of five federally funded HIT demonstration projects designed to lay out a national blueprint for improving the quality of health care while reducing costs in the healthcare system.

The State has reached a tentative agreement with TennCare enrollee attorneys and stakeholders that would preserve health coverage for approximately 97,000 "medically needy" enrollees -- the sickest and neediest who generally do not qualify for Medicaid -- in exchange for relief from certain legal constraints related to TennCare.

The proposed reform allowed TennCare to disenroll over 190,000 individuals including: 1) persons who were dually eligible on Medicare; 2) persons who are uninsurable but are eligible to transfer coverage under federal HIPAA rules; and 3) uninsured adults who could conceivably obtain insurance elsewhere. The disenrollment started June 2005. The proposed reform will limit pharmacy benefits and medical services for those adults remaining on the program. However, it does not affect the benefits of children or pregnant women.

In an effort to help the disenrolled population, Governor Bredesen appointed a "safety net" task force to make recommendations. The Governor's Task Force on the Healthcare Safety Net, the 26-member Task Force of healthcare professionals, state lawmakers, cabinet officials and local representatives, delivered its final report in May 2005 outlining 16 broad recommendations for strengthening safety net options in conjunction with reforms to TennCare. This "safety net" subsequently doubled the Department of Health's primary care clinic capacity and substantially expanded capacity in selected community clinics as well as in federally qualified health centers.

During the presentation of his 2006 State Budget, Governor Bredesen announced a series of initiatives to expand access to health insurance for uninsured Tennesseans, which he entitled "Cover Tennessee". The targeted populations included broadening the SCHIP eligibility to include more children and subsidizing an affordable health insurance premium for employees of small businesses. In addition, the governor rolled out a plan to offer more preventative and improved treatment of the State's citizens with diabetes.

Cover Tennessee is an umbrella initiative with five targeted programs, including three health insurance products and pharmacy assistance: 1) CoverTN for employees of small businesses and self-employed individuals; 2) CoverKids for children and pregnant women; 3) AccessTN for individuals who are uninsurable due to their medical condition; and 4) CoverRx for stop-gap prescription drug help. All are currently accepting applications.

CoverTN is the centerpiece of this health care program. At its heart, CoverTN is a partnership between the state, individuals and small businesses. It offers affordable, portable and basic insurance coverage to those who have not been able to afford comprehensive coverage. The program pays for what is most important and cost-effective; and, it incorporates the concept of personal responsibility.

CoverKids offers comprehensive health insurance coverage to children 18 years-old and younger. Benefits are similar to those offered to dependents of state employees with emphasis on preventive care such as vaccinations, well-child visits and developmental screenings and maternity coverage for pregnant women.

CoverKids features no monthly premiums, but each participant will pay reduced co-payments for services. A family of four with a household income of $51,625 (250 percent of federal poverty level) or less is eligible. Families above the income limit may purchase coverage for their child by paying monthly premiums.

AccessTN was created for individuals with one of 55 specified medical conditions, or those who are unable to get insurance in the commercial market because of their health status. There is no

income test for this program and premium assistance is available for low-income individuals.

CoverRx is designed to help those who have no pharmacy coverage, but have a critical need for medication. For many folks, access to prescription drugs for chronic conditions can mean the difference between debilitating illness and a productive life.

/2009/ Update on Cover TN Efforts: Throughout the 2007-08 year, the administration has sponsored "Call in events" statewide. In these events, Cover Tennessee representatives answer questions about CoverKids, CoverTN, CoverRx and AccessTN. The most recent event coincided with Cover the Uninsured Week 2008, April 27 to May 3, a national effort to highlight the fact that too many Americans live without health insurance. Callers ask questions about the programs, find out if they qualify, and to obtain assistance with the application process. Callers would have basic information available to enroll, such as Social Security numbers and income information for CoverKids, CoverRx and AccessTN, and federal employer identification numbers and Tennessee employer account numbers to enroll in CoverTN. //2009//

Heart disease and stroke continue to be leading causes of death in Tennessee. Tennesseans also report a high prevalence of diabetes. In 2004, these three diseases resulted in premature deaths that translate to 124,283 years (almost doubled since 2002) of potential life lost for Tennesseans. A contributing factor to these diseases is obesity, and Tennessee ranks 8th worst in the nation for the percentage of adults who are obese. According to the results of the 2004 Behavioral Risk Factor Surveillance Survey and data collected by the Department of Health, an estimated 34 percent of adults in Tennessee do not exercise at all. Six out of ten adults reported being either overweight or obese. Tennessee has the 4th highest smoking rate in the nation, with approximately 26 percent of adults being smokers. Seven out of ten people do not eat the recommended amount of fruits and vegetables. In 2002, more than 13,000 babies were born in Tennessee to mothers who smoked. Prenatal care was inadequate in 11.2 percent of live births in Tennessee in 2002.

Diabetes is also a leading cause of death and morbidity in the state. In 2006, the Governor launched "Project Diabetes" to help combat this killer. The initiative was subsequently housed in the Department of Health. The Community Services section helped implement the Tennessee Center for Diabetes Prevention and Health Improvement. The Center will make funds available to support implementation of innovative, evidence-based programs focused on the prevention and/or treatment of diabetes. The purpose of the Center is to develop and promote a statewide effort to combat the proliferation of Type 2 diabetes. As part of this effort, the Center intends to provide program implementation grants to providers of primary and specialty health care services related to the development of programs for prevention and treatment of pre-diabetes and diabetes.

/2009/ Update on Diabetes Prevention efforts: The Tennessee Center for Diabetes Prevention and Health Improvement awarded $342,000 in planning grants to seven organizations across the state. The funding will be used for efforts to prevent and treat patients with diabetes. The Project Diabetes planning grants will be used to fund a variety of education, treatment and prevention initiatives designed to reduce the burden of diabetes in Tennessee. //2009//

The Department of Health gained new leadership in Commissioner Susan Cooper in January 2007. The Commissioner brought a track record of developing and coordinating preventive health efforts.

Commissioner Cooper brought GetFitTN to the Department in 2007. GetFitTN is a statewide awareness program developed by Governor Phil Bredesen to address the rising epidemic of Type 2 diabetes and risk factors that lead to diabetes, like obesity. This initiative is aimed at educating both adults and children that Type 2 diabetes can be delayed or even prevented with modest

lifestyle changes like increasing physical activity and a healthier diet. The Department of Health has developed a website with resources including interactive tools for an individual to develop and implement personal health and wellness goals.

/2009/ In the fall of 2007, Commissioner Cooper led the Department's charge to decrease tobacco use in the 1 million Tennessee smokers. This massive effort had several parts and preceded the law to ban smoking in any enclosed establishment as well as parks, and sports venues if persons under the age of 18 years attended. The effort assisted in targeting teens, prenatal and postpartum women. It included: 1) evaluating all health department clients, 13 years or older, with a survey, and implementing the evidenced-based 5As or 5Rs approach; and 2) if client expressed the desire to stop tobacco use, he/she was offered smoking cessation counseling through the Tennessee QuitLine, and/or pharmacologic treatment. This effort has met with fairly rapid success, significantly increasing the number of QuitLine users and persons agreeing to take smoking cessation medications. //2009//.

B. Agency Capacity

B. Agency Capacity (Due to the small amount of characters left for this section for FY 09, we were unable use required format without deleting sections. Thus the section has been updated throughout.)

The state has local health departments in all 95 counties that carry out health related programs for women, infants and children. Local health departments operate in collaboration with the county executive or mayor and county commissioners. Metropolitan counties have boards of health which set general policy for their health departments. Funding for local and metropolitan health departments comes from local, state and federal government sources, third party payers and client fees. Maternal and Child Health funds contribute to the financial base of all county health departments.

Each county has one or more health department sites delivering health services, including family planning, child health, EPSDT, immunizations, home visiting services, care coordination for families with children with special health care needs, pregnancy testing, basic prenatal care, prevention and treatment of sexually transmitted diseases, WIC, and TennCare outreach and advocacy. Other services (primary care, prenatal care, tuberculosis and HIV/AIDS management, etc.) are provided at selected sites depending upon need and availability of resources. The Department (TDH) contracts with universities, hospitals and other agencies for services such as perinatal regionalization services, genetics, children's special services, additional family planning sites, abstinence only education and child care technical support services. Primary care services are provided by 54 of the 95 county health departments designated as TennCare primary care providers and provide 24-hour coverage and referral (after hours needs are handled by telephone).

While certain basic health services are available at local health departments regardless of health care coverage status, others are negotiated with the managed care organizations (MCOs) based on gaps in the health care delivery system. The Department contracts with those MCOs operating in the rural counties to provide some traditional public health services without prior authorization from the MCO. Other health services can be provided to women, infants and children if individual authorization is approved. Staff are very involved in care coordination and case management to assure that women, infants and children enrolled in TennCare receive the services they need.

Description of Children's Special Services (CSS) Program:

Children's Special Services (CSS) is the state's Title V CYSHCN's program. Children's Special

Services addresses the special health care needs of children from birth to the age of 21 years who meet both medical and financial criteria. State statue defines children with special health care needs as: "A Child under the age of 21 who is deemed chronically handicapped by any reason of physical infirmity, whether congenital or acquired, as a result of accident of disease, which requires medical, surgical, or dental treatment and rehabilitation, and is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic."

Children Special Services has an established financial criterion of income not greater than 200% of the federal poverty level. The program financial guidelines are updated by April 1st of each year. In order to assist families in qualifying financially, the CSS program will use spend-downs including; premiums paid to other health insurances, payments for child support, and any paid medical bills incurred over the past year for the entire family.

CSS provides reimbursement for medical care, supplies, pharmaceuticals, and therapies directly related to the child's diagnosis. Medical services are provided through a network of CSS and TennCare approved providers. Each family is required to apply for TennCare and assisted in finding a medical home as well as any needed specialists.

CSS conducts various multidisciplinary medical clinics in the regional offices, university hospitals, and other private provider offices. Comprehensive pediatric assessment clinics are only held in 1 of the 13 regions/metros due to primary care services being conducted through TennCare and its physician provider network. CSS holds numerous orthopedic clinics and craniofacial clinics throughout the state. Since most children have some form of health insurance, including TennCare, the program makes every effort to obtain reimbursement for medical services.

All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available. Approximately forty-one percent or 2,289 of the 5,570 CSS enrollees have SSI.

CSS provides care coordination services to all its clients in all 95 counties. Care coordination services are provided by social workers and public health nurses and include: assessments of both medical and non-medical needs, and serving as a liaison between the medical provider, insurance company, transportation services, and the family. CSS care coordinators may attend CSS clinics, private clinics, and multidisciplinary meetings in the educational setting.

Children's Special Services recognizes the need for parents of a recently diagnosed child to talk and meet with other parents of a similar or like diagnosis child, so those parents can impart their knowledge, understanding and experience. If a family cannot be referred to another parent of a similar or like diagnosis then the family is referred to the national Mothers Understanding Mothers (MUMS) organization. At present, CSS does not reimburse the $5.00 fee for using the MUMS service.

Project TEACH (Together Educating and Coordinating Health) provides coordination of services for CYSHCN in the school system as well as assisting the schools in processing payments from third party insurance companies, including TennCare. The program is staffed by nurses and social workers who coordinate efforts in 45 of Tennessee's 139 school systems. Over the past few years, millions of dollars have been saved by the school systems by accessing other payment sources, but more importantly children have been identified as needing services that would not have received needed care.

Description of preventive and primary care services for pregnant women, mothers and infants:

All local health departments provide pregnancy testing, counseling, and referral for prenatal care;

HIV testing and counseling; WIC and nutrition services; presumptive eligibility for pregnant women for TennCare/Medicaid (pregnant women below 185% of the federal poverty level are eligible for TennCare); and testing for sexually transmitted diseases. ***/2009/ To qualify for Presumptive Eligibility, four criteria must be met: Tennessee residence, valid social security number, household income at or below185 % federal poverty level, and verification of pregnancy.//2009//***. Staff assist with referrals to the Department of Human Services, which is responsible for TennCare enrollment. Staff also provide outreach and advocacy services for TennCare enrollees, including assistance in accessing medical care by identifying providers and setting up appointments, reminder phone calls, assisting the enrollee in understanding the TennCare system, assisting with appeals, and educating enrollees about the important concepts of a medical home, use of the primary care provider, and preventive health education. All regions have home visiting services for pregnant women and infants considered to be at risk and in need of such services.

The state's perinatal regionalization system consists of the five regional perinatal centers, making high-risk obstetrical and neonatal care accessible to all physicians and health care facilities statewide. This system provides a mechanism for consultation regarding high-risk pregnant women and infants and a system of referral and transfer, when necessary. The system also provides postgraduate education in perinatal medicine for health care providers. Access to the appropriate level of high-risk care is facilitated through the agreements among delivering hospitals, physicians and the centers. The perinatal regionalization system has a 21-member Perinatal Advisory Committee staffed by Women's Health. During FY 2007, there were 14,505 deliveries at the five Regional Perinatal Centers, 4,487 NICU admissions, 1,610 newborn transports, 1,027 follow-up clinic visits, and 5,716 educational hours provided to health care providers. Staff at the Centers provided approximately 2,388 documented telephone consultations and 19,401 onsite patient consultations.

Family planning services are available in every county at 130 clinic sites (health departments, Planned Parenthood agencies, primary care sites). Services include counseling and education, exams, laboratory tests, and contraceptive supplies, and are available upon request to any reproductive age person. During CY 2007, the program provided services to 122,753 persons.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Program provides nutritional counseling and education, supplemental foods and health care referrals to approximately 169,000 eligible participants. Participants are pregnant, post partum or breastfeeding women, infants and young children under five years of age who are at risk of poor growth and development and who meet the required income guidelines. WIC services which include nutrition education, referals and vouchers for food are provided at approximately 135 local health department, primary care, and hospital sites throughout the state. Nutritionists provide education and information to individuals or groups regarding nutrition and physical activity, and other healthy behaviors for everyday living. Registered dietitians counsel individuals with special dietary needs such as gestational diabetes, PKU, and food allergies. Breastfeeding promotion and support are also available statewide.

The state Genetics and Newborn Screening (NBS) Program requires by law that all babies be screened for metabolic disorders prior to discharge from the birthing hospital. The Program has established a network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases, including sickle cell. The NBS follow-up nurses are located at the State Laboratory to assure that all abnormal results are reported as quickly as possible. The program involves cooperation between birthing hospitals, the State Laboratory, the NBS Program staff, the Genetic centers, Sickle Cell Centers, endocrinologists, Cystic Fibrosis Centers, and primary care physicians. The state is currently testing for 41 diseases (which may reflect 57 different genetic disorders). For additional information, see NPM #1.

Newborn Hearing Screening - CY 2007 data indicated that all 82 birthing facilities provided

hearing screening to 85,077 (92.5%) of the birth population. The number of infants referred for further hearing screening was 3,679 (3.6%). An estimated 46 infants were diagnosed with hearing loss in March 2008, and 150 have results pending. There has been no mandate for hearing screening, however birthing facilities are required, by Rules, to report hearing screening results on the state metabolic/genetic blood spot form. Tracking and follow-up for hearing screening is conducted in conjunction with the metabolic Newborn Screening Program. Education for hospital hearing screening staff, medical, providers, audiology providers, early intervention (Part C) staff and families is provided by the Tennessee Newborn Hearing Screening Program (NHS). NHS monitors the progress of screening and reporting of all birthing facilities by conducting hospital surveys, parent satisfaction surveys and site visits to hospitals and audiology providers. Tennessee does not have a CDC Early Hearing Detection and Intervention (EHDI) grant. There are over 70 pediatric audiology provider sites and 6 cochlear implant sites. NHS contracts with the Tennessee Center on Deafness for an Audiology Consultant (0.5 FTE) and with Family Voices for three Parent Consultants (0.25 FTE each). The Tennessee Early Intervention System (TEIS), by Rules and by a cooperative agreement with the Department of Education, IDEA Part C program, provided follow-up and tracking for 1,791 infants in need of follow-up. Infants diagnosed with hearing loss are referred for enrollment into TEIS and referred to the Department of Health, Children's Special Services (CSS) program. For additional information, see NPM #12. The 2008 Legislature passed a bill mandating newborn hearing screening for all infants born in Tennessee with reporting of results to the Department of Health. Signature by the Governor is pending.

Child Health: The CHAD home visiting program continues to be partially funded by the Tennessee Department of Children's Services. In FY 2007, CHAD served 773 families, which included services to 1,108 children. CHAD provided services in 22 Tennessee counties. In FY 2005 Sullivan County offered all of its home visiting services through the HUGS program rather than offering both CHAD and HUGS. In FY 2007, the Healthy Start program served 1,508 children. In FY 2006, the CHAD program served 807 families, which included 1,236 children. The Healthy Start provided services in 27 Tennessee counties. In FY 2007 the Healthy Start program served 1,388 families, which included 1,508 children.

EPSDT: All 95 county health departments continue to provide EPSDT screenings to TennCare eligible children. In FY 2006/2007, 58,276 screenings were done by the health departments. As previously reported, the Department of Health assumed the responsibility of screening children in the custody of the Department of Children's Services in June 2003. Data for 2006-07 from DCS show that 95% of children had been screened. The TENNderCare Community Outreach program, the TENNderCare Call Center program and the TENNderCare Nursing Call Center, raise awareness of the importance of EPSDT screening to parents of TennCare eligible children.

ECCS: Early Childhood Comprehensive Systems (ECCS) has created a diverse, statewide advisory committee that comprises a network of representatives from State departments, public and private agencies, parents, advocates, representatives of faith-based organizations, the Academy of American Pediatrics, Head Start, the Governor's Office of Children's Care Coordination, the Governor's Children's Cabinet, United Way- Success by Six and Child Care Resource and Referral Network. The primary objective of ECCS is to develop strategies to identify gaps in service and to outline long term plans for a seamless system of care that has a positive impact on school readiness of children. The ECCS Executive and advisory committee will continue to meet quarterly to monitor the status and ensure implementation of approved State plan, analyze existing needs assessment data and identified problem areas affecting the healthy growth and development of the targeted population -- all children birth to five years of age. Their current charge is to specifically address the five critical elements of the grant: Access to Medical Home and Insurance; Early Care and Education; Mental and Socio-Emotional Health; Parenting Education; and Family Support. Members are assigned to one of the workgroups based on these critical elements and the individual sub-committees continue to plan result-focused strategies by phone conferences and e-mail communications. Working cooperatively, MCH staff who selected early childhood indicators at ECCS meetings now facilitate these workgroups by sharing their expertise in special needs, school health issue and environmental influences such as lead

poisoning. The ECCS Program Director is solely responsible for the coordination of the grant, planning advisory committee activities and insuring that there is a transition of the CISS grant along with continuation of the objectives of the Healthy Child Care America program, thus she attended the 2008 Early Childhood Systems Building Partners Meeting Pre-Work in Washington, DC.

The ECCS Program Director was responsible for identifying members to participate in a state team to travel to Washington, DC in March 2008. She recruited members for the team from the following areas: The Office of Head Start Collaboration; Strengthening Families; Voluntary Pre-K; the Department of Mental Health and Developmental Disabilities and Early Childhood Comprehensive Systems. Although, travel to Washington, DC to participate in the Joint Meeting, was a conflict for some of the team members, a meeting was held prior to the travel, and feedback was collected from each team member and discussed at the Joint meeting.

The ECCS support for the Center for Social and Emotional Foundations for Early Learning(CSEFEL)/Tennessee partnership include ECCS serving as the home for CSEFEL/Tennessee initiative with support and the development of a database to track contacts inquiries for services.

ECCS and Team Tennessee is now working toward the actions for the Roll-out event(s), train the trainer/coaches for selection, to provide child care trainings. The ECCS Program Director is assisting in developing a cadre of professional child care trainer.

The ECCS Program Director/CSEFEL are preparing to initiate the process for identifying three (3) local programs to serve as demonstration sites to demonstrate the effectiveness of the Pyramid Model and practices in each site. In addition, ECCS is also a part of the states team for Project Thrive policy project the CSEFEL grant.

This team participated in "Strengthening State Systems to Promote Early childhood Development: Moving to the Next Level". This workshop provided support and expertise to the state teams in an effort to empower them in their efforts to conduct cross-agency work more efficiently and effectively.

The ECCS Program Director will be participating in a state team led by Tennessee Early Childhood Training Alliance (TECTA). The team members represent Head Start, Department of Education, Office of Early Learning -- Voluntary Pre-K, Early Childhood Comprehensive Systems, and the Child Care Resource and Referral Agency. This state team will build upon the plan of action outlined at the January 2007 meeting with a focus on moving cross-sector efforts forward. In an effort to participate in other initiatives and efforts, the ECCS Program Director holds a position on the following committees or partnerships: Tennessee Department of Health: State Pre-K Alliance:
Tennessee Department of Health, Special Education: Tennessee Early Childhood Inclusion Collaborative:
Vanderbilt Kennedy Center for Research on Human Development: Early Child Care Training Task Force Centerstone, Columbia: Early Childhood Network Tennessee Department of Human Services Partners:
The Department of Children Services: Strengthening Families.

As of December 2008, the ECCS Program Director will complete training for Child Care Health Consultant. She is currently enrolled in the National Training Institute for Child Care Health Consultants. The program is coordinated and facilitated by faculty and staff at the University of North Carolina at Chapel Hill.

Tennessee's initial goal for the Child Care Health Consultant initiative will be to provide training to Child Care Resource & Referral (CCR&R) Health Coordinators. At least one CCHC will be established within each of the eleven regions of CCR&R. Training will be conducted state-wide in

an effort to continue to strengthen the efforts to improve the health and safety of children in out of home care.

Licensed child care providers will have an opportunity to request help or information from a CCHC. This affiliation will empower providers to improve their programs making them a healthier and safer place. We anticipate an improvement in the rating scores in the areas of health and safety in licensed child care facilities.

Child Care Resource and Referral Centers (CCR&R): There are more than 4,900 regulated child care providers with a capacity to serve more than 330,000 children. The staff of the 11 Resource and Referral Centers include child care specialists as well as specialists in other areas related to child care such as Infant & Toddler Specialists. Direct services rendered to child care providers included over 3,000 training sessions, on-site consultations, and use of regional lending libraries -- most related to the prevention of health and safety problems for the children served. Indirect services included community presentations, a quarterly newsletter, and a CCR&R website linked to the Department of Health's site. Parent referrals are routed over a toll-free phone number that is promoted locally in a colorful brochure. Community participation is noted by CCR&R involvement with several advisory boards including the Early Childhood Comprehensive Systems (ECCS) and the Tennessee Association for the Education of Young Children (TAEYC).

MCH provided partial funding for the salaries of the health specialists, books, and audio-visual teaching materials for each of the lending libraries. In Spring 2008, a Health and Safety training video series was created with funding in part from MCH. The intent of the video series is to provide training to child care providers on guidelines and tips to improve health and safety outcomes in licensed child care facilities. In partnership with the Department of Human Services and Signal Centers, future training will focus on improving health and safety scores on the Star-Quality Assessment Program.

Adolescent Health: The Adolescent & Young Adult Health in Tennessee Report, an Executive Summary, and Fact Sheets were distributed to stakeholders including public health staff and community agencies. This information was made available on the Tennessee Department of Health, Adolescent and Young Adult Health Program at http://health,state.tn.us/MCH/Adolescent/adolescent index.htm. A youth health guide, Your Health is in Your Hands, was distributed to over 40,000 young people through the community adolescent health coordinators, contacts working in schools, the faith community, youth organizations, and TenderCare. Conference planning and underwriting was provided for the Yes2Kids Conference.

The adolescent health director facilitates the Adolescent Health Advisory Committee and the State of Tennessee Asthma Task force (STAT). She serves on various committees such as: the Tennessee Healthy Weight Network, a network that represents a public/private partnership of over 30 state and private organizations committed to addressing the obesity epidemic within Tennessee; the Tennessee Suicide Prevention Network participating on the Interdepartmental Committee and attends statewide Advisory Council meetings; and the Coordinated School Health Advisory Committee. The director collaborates with the National Center of Youth Issues (NCYI), a community youth service agency, to plan the annual, statewide Celebrating Healthy Choices for Youth Conference.

Child Fatality Review Team (CFRT) - The state's child fatality review system provides an additional data source for determination of need for action within the targeted populations. Child Fatality Review Teams (CFRT) reviewed 1,069 (98.3%) of the 1,087 fatalities of Tennessee resident children under age 18 that occurred in 2005.

Department of Health team leaders provided administration and coordination of the teams. The CRFT reviewed the way children died (Manner of Death) in Tennessee and what caused the deaths (Cause of Death).

Sudden Infant Death Syndrome (SIDS) -- The SIDS program includes making autopsies available for every suspected SIDS death and providing support to parents and their families through published materials, home visits by a public health nurse, and referral for counseling and association with parent groups of those who have experienced a SIDS death. A law mandating the Departments of Health and of Children's Services to train first responders (Emergency Medical Technicians, professional firefighters, and law enforcement officers) in conducting the Death Scene Investigation of the sudden unexplained death of a child has progressed. This training entitled "Prevention Through Understanding" must include information about SIDS and responding to a grieving family. In April 2008, a Death Scene Investigation In-service for Trainers was conducted at MTSU. The curriculum manuals and the in-service program have been approved for in-service and pre-service training by the Commission for Law Enforcement, the State Commission Board for Fire Fighters, and the Board of Licensure and Education for Emergency Medical Services. "Prevention Through Understanding" has been approved for five contact hours for trainers who go through the program and for two contact hours for trainees who attend a trainer in-service or pre-service program. To date, a total of 2,990 Emergency Medical Technicians and Paramedics; 1,504 First Line Supervisors/Managers of Fire Fighting/Prevention Workers; 23,000 Fire Fighters; 1,332 Criminal Investigators; and 15,600 Police and Sherriff's Patrol Officers have been trained.

Childhood Lead Poisoning Prevention Program (CLPPP): The Childhood Lead Prevention Program Program's purpose is to identify children with elevated blood lead levels and prevent childhood lead poisoning. Through extensive collaboration with public and private partners, the state has developed a program targeting areas of highest risk of childhood lead poisoning based on old housing, children in poverty, and number of low income housing units.

Dental Health: Dental services are required under EPSDT guidelines that are to be followed by the MCOs. There are significant shortages of dentists in MCO networks, and some areas of the state have no dental services available. To counteract this shortage, the Rural Health Initiative allows health regions to submit proposals through their Regional Health Councils to establish special dental, obstetric, pediatric and/or primary care services needed in their communities. Fifteen projects have been approved for funding under this new initiative. Many have chosen to develop mobile dental services targeting school children during the school year and providing services to others during holidays and summer. See NPM #9 for more information

Help Us Grow Successfully Program (HUGS): Program goals are to reduce complications of pregnancy, subsequent unplanned pregnancies, developmental delays in children, and maternal and/or infant morbidity and mortality through home visiting services and a case management model. Services are targeted to prenatal and postpartum women up to two years after delivery (including women who have lost a child due to miscarriage, stillbirth, prematurity, SIDS or other causes) and children birth through the age of 5 years. These services assist clients in gaining access to health care (well-child checks, immunizations, EPSDT, WIC, etc.), psychosocial, educational and other necessary services to promote good health practices and improve general well-being. The program continues to expand services by working with the Child Fatality Review staff to receive referrals and provide services to women who have lost a child under age two. Services are provided to assist these women and their families cope with the grieving process and improve the outcome of future pregnancies. 22,851 visits were made in FY 2003, 32,467 in FY 2004 in FY 2005 38,895 in FY 2006 47,254, in FY 2007 52,722 and it is estimated to reach more than 55,000 in FY 2008. The increase in visits may be due to the additional staff added during FY 2004. The HUGS staff consist of 175 nurses, social workers and paraprofessionals as well as 14 Program Directors to coordinate seven regional, six metropolitan and one faith-based site. The program currently serves 89 of the 95 counties across the State of Tennessee. Plans are currently underway to expand home visitation services to the 6 additional counties. In addition, plan are underway to automate the data collection component.

Description of culturally competent care appropriate to MCH population:

Language barriers pose challenging communication issues at almost every level of the health care delivery system. The continuing increase in Spanish speaking populations has created a critical need for appropriate language services by health care providers across the state. The Department contracts with Open Communications International (OCI) to provide over-the-phone translation services (mainly for languages other than Spanish) for rural health department clinics. Assistance with over 170 different languages is available. Through a toll-free number, interpreters can be accessed 24 hours a day. OCI has provided materials to all health departments to inform non-English speaking clients of this service and allow them to visually indicate their preferred language.

The Department also contracts with the Tennessee Foreign Language Institute for translation services of written materials and interpreter assessment. The Department has developed and implemented Title VI Policies and Procedures for limited English proficiency, which are applicable to all Health Services Administration programs that are receiving federal financial assistance. Topics covered include data collection, analysis and reporting, oral language interpretation, translation of written materials, providing notice to LEP persons, staff training, and quality management.

State statutes relevant to Title V program authority are discussed as follows:

TCA 68-12-101 to112 - The Crippled Children's Act of 1934 establishes state services for children with special health care needs who meet income and diagnostic guidelines. The Act further establishes an advisory committee and directs that certain geographic requirements be met.

TCA 68-5-401-503 - The Genetics and Newborn Screening Act establishes the statewide program responsible for screening and follow-up with all babies born who have questionable or confirmed lab results for genetic and inborn errors in metabolism.

TCA 68-142-101-109 -The Child Fatality Review Act of 1995 requires that review teams be established in each judicial district of the state and that all deaths to children under the age of 18 are reviewed. It further requires that an annual report is written and that a statewide advisory group is convened at least annually by the Commissioner to review findings and recommend policy.

TCA 71-3-151-165 - The Welfare Reform Act of 1996 requires that TDH, through the local health departments, provide home visiting services to families with young children within 30 days of termination from the program for reasons other than self-sufficiency.

TCA 37-3-703 - Establishes the Hawaii model of Healthy Start for families at risk of child abuse and neglect.

TCA 68-34-101-111 - The Family Planning Act of 1971 established the statewide family planning program, which included availability of contraceptives, eligibility for services, disposition of funds and services to minors.

Associated statutes related to maternal and child health issues are implemented by other sections of the Bureau of Health Services. The Traumatic Brain Injury Program (TCA 68-55-101-402) establishes the head and spinal cord injury information system and advisory council; TCA 68-143-101-103 establishes a statewide public awareness campaign for shaken baby syndrome addressed jointly by the Departments of Health and Human Services. Tennessee was one of the first states to legislate child safety through the required use of child safety seats (TCA 55-9-602-610), which took effect in 1977. A Child Bicycle Safety Act (TCA 55-52-101-106) was passed in 1994 requiring all operators and passengers under the age of 16 riding on a state roadway to wear approved protective bicycle helmets and defines additional requirements for other riders. State statute declares it an offense to transport a child under 6 years old in the bed of a pickup

truck on any roads of any county or state highway.

Legislation from the 2007-08 sessions included: (1) establishment of a statewide Fetal Infant Mortality Review Process; (2) establishment of Home visiting Fund and a pilot evidenced -- based home visiting program;
(3) several tobacco cessation laws including one to eliminate smoking in restaurants and public buildings;
(4) establishment of Nurse Family Partnership Pilot; (5) Formulation of comprehensive State plan to approach asthma in schools; and (6) changing the funding criteria for family planning organizations.

C. Organizational Structure

C. Organizational Structure

The Tennessee Department of Health is a branch of state government with a commissioner appointed by the Governor. There are thirteen regions under the state health department serving the 95 counties. Seven of the regions are comprised of rural counties, and six are comprised of metropolitan counties under the jurisdiction of metropolitan city councils/government. The counties in the seven rural regions are a part of the state's administrative system, whereas the six metropolitan counties are a part of the county administrative systems. Each county has a local health department with at least one clinic site. The central office of the Department, including Maternal and Child Health and Women's Health/Genetics, functions as the support, policy-making, and assurance office for the public health system. Central office program staff works closely with staff in both rural and metropolitan regions on all program activities. The primary difference between the two types of regions is the method used to provide funding. Rural regions are part of the state government system, and metropolitan counties are separate city/county government systems. Both operate maternal and child health programs using the same standards and guidelines. The central office provides support and technical assistance to both rural and metro regions.

The Department of Health has a range of responsibilities, including administering a variety of community-health programs, licensing health care professionals and maintaining health records and statistics. The Department works closely with local governments and nonprofit agencies to monitor and improve community health. The Department is organized into three bureaus and seven support sections. The Bureaus are Alcohol and Drug Abuse Services, Health Licensure and Regulation and Health Services Administration (HSA). The support sections include the State Laboratory, Office of Minority Health, Office of Policy, Planning, and Assessment, Office of Human Resources, Office of General Counsel, Office of Communications, and Office of Information Technology. The Maternal and Child Health Section and the Women's Health/Genetics Section are in the Bureau of Health Services Administration along with several other sections providing services across the state (Communicable and Environmental Disease Services, WIC/Nutrition Services, Community Services, General Environmental Health, HIV/STD, Medical and Dental Services, Regional and Local Health). ***/2009/ The Bureau of Alcohol and Drug Abuse services was moved to the Department of Mental Health and Developmental Disabilities. The third Bureau is now the Bureau of Administrative Services. The office of Minority Health became the Division of Minority Health and Disparities Elimination//2009//***

Maternal and Child Health services are housed within two sections of the HSA Bureau. MCH consists of Child and Adolescent Health Services, and Children's Special Services. Women's Health/Genetics consists of Genetics and Newborn Screening Services and Women's Health. Organizational charts for the Department, the Bureau of Health Services Administration, Maternal and Child Health, including Services for Children with Special Health Care Needs, and Women's Health/Genetics are available upon request.

The administration changed with the second term election of Phil N. Bredesen as Tennessee's 48th Governor in November 2006. In January 20, 2007, Governor Bredesen named Susan R. Cooper, MSN, RN., to serve as the Commissioner of Health.

Susan Cooper joined State government in September 2005 serving as special policy and health advisor, and was instrumental in developing Tennessee's Health Care Safety Net. She later assumed leadership of Project Diabetes, a program Governor Bredesen created to curb the Type II Diabetes threat facing young Tennesseans. Cooper also helped facilitate GetFitTN, the public awareness portion of Governor Bredesen's campaign to promote healthier lifestyles and habits among Tennesseans.

Before joining State government, Cooper was a faculty member and assistant dean at Vanderbilt University's School of Nursing, where she received both her bachelor and master of nursing degrees. Currently pursuing a Doctor of Nursing Practice from the University of Kentucky, Cooper has an extensive background in vulnerable populations, program planning and evaluation, health policy, healthcare regulation, and evidence-based practice. In addition to serving as a public health nurse, Cooper's career experience also includes work as a nurse specializing in emergency and intensive care.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. By state law, there is a health department in every county; highly populated counties may have several health department sites. Title V has played an increasingly important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs (CSHCN). Tennessee's local health departments in all 95 counties, carry out health related programs for women, infants and children. The Department of Health is responsible for the overall administration of the Maternal and Child Health Block Grant funding and all the programs, projects, and activities which are components of maternal and child health.

Funds that support MCH section activity include several special funding sources in addition to the MCH Block Grant. The state's award for State Systems Development Initiative (SSDI) has been used to develop the computer network and data management infrastructure. This funding stream has benefited not only MCH but also the other sections of the Bureau of Health Services since SSDI funds were used to develop an integrated database on clients and services for program management called PTBMIS, which is used by all health service programs. SSDI funds have also been used to upgrade the hardware and software used in the Genetic and Newborn Screening Program, which is under the direction of MCH and fulfills the state mandate to screen every baby born in the state for metabolic disorders.

/2009/ SSDI funding is currently being used to provide critical information from linked data sets to assist in programatic decision-making. In addition, MCH has received funding since 2003 for the state's Early Childhood Comprehensive System program which replaced the CISS grant. //2009//.

The state's Abstinence Education Program is under the direction of MCH. The federal funds supporting this program are being used to support 18 projects in community based organizations. A statewide fall conference on the importance of abstinence until marriage and character education for school aged youth has been held annually since September 1999.

/2009/ Due to the short funding extensions offered by Congress for FY 07-08, the department decided to discontinue the State's Abstinence education program. The brief extensions did not afford the State enough time to establish new contracts and monitor vendor performance, a result of a Request for Grant Proposal process that was completed in April 2007.//2009//.

The Childhood Lead Poisoning Prevention Program is under the direction of MCH. Funding is provided for screening, follow-up, education of providers and the general public, and surveillance/data collection in 94 of the 95 counties (excluding Shelby). Effective July 2003, a three-year cycle of funding from the CDC combined the two programs into one statewide effort. In 2004, 49,547 children ages 6-72 months were screened; 262 had a confirmed blood lead level >10 ug/dl. For 2005, 53,887 children ages 6-72 months were screened; 237 had a confirmed blood lead level >10 ug/dl.
/2009/ MCH did not submit an application for funding for the 2007-2010 cycle. //2009//.

The Women's Health/Genetics Section is responsible for the Title X family planning program which provides comprehensive family planning services in all 95 counties through 130 clinics, including local health department clinics, planned parenthood agencies, and primary care centers. For 2007, the program served 122,753 clients, of which 87.6 % were at or below 150% of the federal poverty level.

The Newborn Hearing Screening Program (NHS) is administered by staff in Women's Health/Genetics. The program is directed by a fulltime public health nurse consultant. Support staff include a full-time clerk and 0.4 FTE administrative services assistant. Newborn hearing contracts for the services of an audiology consultant (0.5 FTE) and three (0.25FTE each) parent consultants. An additional parent consultant will be added July 1, 2008. Team members provide program development and training. A Newborn Hearing Task Force meets quarterly to assist in the development of policies, guidelines and other activities to support the program. The NHS program is supported by a Health Resources and Services Administration, Universal Newborn Hearing Screening Program Grant CFDA#93.251. A new 3-year grant cycle began 8-1-08. Completion of the goals and objectives of the grant continue to be on track. The focus of the new grant is to reduce loss to follow-up, increase hospital involvement in providing families appointments of resources for follow-up hearing appointments prior to discharge , to increase the reporting of infants diagnosed with hearing loss; enrolled in the Department of Education, Part C, Tennessee Early Intervention System; and referred for family support services. The program is in the process of applying to Centers for Disease Control prevention for a grant for Early Hearing Detection and Intervention Tracking, Surveillance and integration. The grant will focus on the integration of data systems related to tracking and follow-up of children and hearing loss. The CDC grant will be directed by the Department's Office of Policy Planning and Assessment. NHS works directly with hospitals, medical providers, audiologists and early intervention to assure screening, testing and services for infants and young children.

MCH administers the Child Health and Development (CHAD) Program that is funded by the Tennessee Department of Children's Services to provide home visiting services primarily to families of abused or neglected children (or those at risk of) in 23 counties.
MCH received an Early Childhood Comprehensive Systems (ECCS) Planning grant June 1, 2003, to create a statewide network of partners to evaluate the current systems capacity, conduct a statewide needs assessment, prioritize identified problems areas, and develop an implementation plan. Transitioning of the CISS grant and sustainability of the Early Childhood Comprehensive System are included. The Child Care Resource and Referral Center staff is an integral part of the ECCS development. The primary objective of the network is to develop strategies to identify gaps in service and to outline long term plans for a seamless system of care that has a positive impact on school readiness of children. The ECCS advisory committee met quarterly to analyze existing needs assessment data and identified problem areas affecting the healthy growth and development of the targeted population- children birth to five years of age. Members were assigned to four workgroups based on the five critical elements and the individual sub-committees continue to plan result-focused strategies by monthly phone conferences and e-mail communications. (Parenting Education and Family Support elements are combined). Working cooperatively, MCH staff who selected early childhood indicators at ECCS meetings now facilitates these workgroups by sharing their expertise in special needs, school health issues and environmental influences such as lead poisoning. On-site consultations and technical assistance was provided by the analyst of Health Systems Research, Inc. of Washington, DC.

MCH combines funds from the Child Care Licensing Division of the Department of Human Services and the Developmental Disabilities Council to fund Child Care Resource and Referral Centers (CCR&RC) in the Department of Human Services (DHS) regions of the state. There are currently 11 Child Care Resource and Referral Centers statewide serving approximately 5,250 regulated child care providers who provide care for 331,230 children. These centers provide technical assistance to all child care facilities in their geographic areas with the goal to improve developmentally appropriate practices; address health and safety issues in child care settings and increase inclusion of children with special needs in established child care programs. MCH assists in training of child care health consultants who are associated with the established child care resource and referral centers. Some of the training is replication of the child care health consultant training developed by UNC -- Chapel Hill for these staff persons. Each of the CCR&RCs employs a professional who serves as a child care provider specializing in health. During 2003, 13,896 participants, not unduplicated, received 30,264 hours of training on child development, early childhood education, health and safety, developmentally appropriate behavior management and child care administration through the Tennessee Child Care Provider Training (TN-CCPT). Each licensed child care provider also receives an annual on-site visit from a CCR&RC specialist. MCH has allocated $150,000 from the Block Grant as one portion of continuation funding for the centers, to support CCR&RC positions and to focus training for the areas in state with the worse health and safety scores. CISS funding is used to support the training of CCR&RC staff.
/2009 CISS funding is no longer available and Block funding is used to support the CCR&R staff.//***2009//.***

Tennessee is one of 23 Center for Disease Control and Prevention (CDC) Coordinated School Health funded partner grant recipients. The Department of Health's Coordinated School Health (CSH) office, which is a part of the MCH section, works cooperatively with the Tennessee State Department of Education, Tennessee State Board of Education, State Universities, Local Education Agencies, School Health advocacy groups, and other interested parties in advocating and advancing the CDC's Coordinated School Health eight (8) component model in Pre-K through grade 12. The State School Nurse Consultant provides guidance to school nurses and school administrative staff across the state on the medical needs of students to include asthma, diabetes, medication administration, and other chronic diseases. Project TEACH nurse consultants, located in eight (8) regional Health Departments, interact directly with schools in accessing and coordinating medical services and Medicaid reimbursement for special needs students. /2009/Tenessee was not awarded one of the 2008-2012 Coordinated School Health grant.//2009//.

D. Other MCH Capacity

D. Other MCH Capacity (Due to the small amount of characters left for this section for FY 09, we were unable use required format without deleting sections. Thus the section has been updated throughout.)

The Maternal and Child Health and the Women's Health/Genetics sections, like other sections of TDH, are organized into three levels of administration and service delivery. The Central Office, consisting of a staff of 36 professional and office support personnel, addresses strategic planning, policy development, program management, contract monitoring and data analysis functions. The seven rural regional offices are responsible for the health services offered in a specified geographic area (between 10 and 14 counties), and the metropolitan regional offices are responsible for the health services offered in each metropolitan county. Staff are primarily located in the Cordell Hull Building in downtown Nashville which houses all the central office administrative offices of the Department, including the Commissioner's office and the Bureau of

Health Services' central office.

The Women's Health/Genetics staff who are responsible for newborn screening follow-up are located at the State Laboratory, which is approximately six miles from the downtown office. At both the central office and regional level, staff administer the programs mandated for women, infants and children and handle all the administrative functions including personnel management, fiscal management, systems development for the Patient Tracking Billing Management Information System (PTBMIS), outreach and coordination with other health service systems including TennCare. Staffs at the regional and local health department levels are under the supervision of the regional director and his/her staff and are not considered out-stationed central office staff.

Within central office, Maternal and Child Health Services is organized into two primary areas, Child and Adolescent Health and Children's Special Services. The section chief is Theodora Pinnock, M.D.. Dr. Pinnock is a pediatrician and completed a fellowship in developmental and behavioral pediatrics. As Assistant Professor of Pediatrics at Vanderbilt Medical Center, she spent five years working in family centered, community and school-based family resource centers focused on maximizing children's readiness for school. She has worked in international settings in London and West Africa in providing medical services for children and adolescents. She has had extensive experience working with a wide variety of agencies, academic medical centers, developmental centers, state legislatures and universities. In May 2008, Dr. Pinnock completed a graduate study certificate in Public Health Leadership. Dr. Pinnock was hired as the MCH director April 22, 2003. Her curriculum vitae is in the attached file.

Child and Adolescent Health Services - This area has several major programs headed by Master's level directors with over five years public health programmatic experience. These programs include Childhood Lead Poisoning Prevention, Abstinence Education, Child Health and Development(CHAD), Adolescent Health, SIDS, Help Us Grow Successfully (HUGS), School Nurse, Project TEACH, Healthy Start, Child Fatality Review and Early Childhood Comprehensive Systems.

Children's Special Services (CSHCN) -- Jacqueline Johnson, BS, MPA, has served in a variety of roles working with children. Her career in public health has been solely with Maternal and Child Health Services. In 2005, Ms. Johnson began working as a public health program director for the Childhood Lead Poisoning Prevention Program, the SIDS Program and the Child Fatality Review Program. Ms. Johnson has a masters degree in Public Administration, Certification in Health Administration and Planning, as well as a significant number of masters level hours in special education. Ms. Johnson was named State CSS Program Director in November 2007.

The other MCH programs, Genetics and Newborn Screening and Women's Health are housed in the Women's Health/Genetics Section. Margaret F. Major, MPA, RD, serves as section chief for the women's health and genetics programs and has worked in public health programs related to women and children since 1969. After 3 years of working in Brazil with international nutrition programs, she joined the Tennessee Department of Health in 1972, working in community nutrition programs, maternal and child health, family planning and women's health. Her current program responsibilities include family planning (Title X), perinatal regionalization, prenatal care, adolescent pregnancy prevention program, women's health, newborn metabolic screening, newborn hearing screening, and genetics and sickle cell centers.

Genetics and Newborn Screening Services -- Cindy Wallace joined Women's Health and Genetics as the Program Director for Genetics, Newborn Screening, and Newborn Hearing Screening in 2007. Ms. Wallace has a master's degree in public services management and is certified as a medical technologist supervisor. She has worked as the manager of the State's Newborn Screening Laboratory, been as assistant professor in a state university's medical technology program, and has worked in the Department of Health for 13 years. The metabolic newborn screening follow-up program activities are headed by a master's level nurse with twelve

years of experience with the program, and 34 years of experience in nursing. The newborn hearing screening follow-up program is headed by a nurse who has been director of the program for over 6 years and has 28 years of nursing experience, all of which has been public health settings.

Within the Department of Health, support functions such as data set development, data analysis, and research are located in the Office of Policy, Planning, and Assessment (PPA). This Office houses a number of data sets which are created and maintained by their staff. These data sets include, birth files, death files, linked birth-death files, hospital discharge, PRAMS, and the birth defects registry. WIC files are a component of the Patient Tracking Billing Management Information System (PTBMIS) which is maintained by the Bureau of Health Services. MCH staff has access to the output data within the PTBMIS files through a system of data CUBES, Staff in Health Services and the Office of Policy, Planning, and Assessment are available for assistance. Data analysis is a cooperative effort within the Department. Data for newborn screening and hearing screening are handled through the Neometrics system for the follow-up program and the State Laboratory.

Personnel from MCH and PPA have teamed up to implement the Tennessee State Systems Development Initiative (SSDI) objectives. These objectives include linking of birth and death files, utilizing geocoding to identify disparities and areas to target for children with elevated blood lead levels, and linking birth certificates to newborn screening information and congenital birth defects. In addition, new goals include linking birth certificates and PRAMS data; and linking birth certificates and FIMR data.

Role of parents: Parents are involved in all aspects of care provided to children and youth receiving services from the Children's Special Services Program. Care Coordinators are assisting families with referrals for needed services to available community agencies or the Mothers Understanding Mothers (MUMS) program. A parent serves on the CSS Advisory Committee for the program.

The Newborn Hearing Screening program includes a component to provide family support to infants and toddlers identified with hearing loss. Services are provided by three newborn hearing parent consultants (0.25 FTE each). They are located in each of the three grand regions of the state. An additional position will be added in the Memphis Metro area in July 2008. Consultants are parents and family members of children with hearing loss. They are contracted through Tennessee Disability Coalition /Tennessee Family Voices, an organization that provides support to families of children with any disability. Consultants have several goals: link families to support each other; build and strengthen family networks; increase resources such as support groups; identify resources for families of children with hearing related conditions; and provide educational materials to the community, medical providers, hospitals, audiologists, and other organizations. The FLASH Family Support group in the Knoxville area is parent run and very active in providing monthly educational and support activities. They planned an area wide Hearing Health Fair for May 2008. Parents attended the CDC/HRSA Early Hearing Detection and Intervention (EHDI) conference in March 2008. Five parents attended the Second Annual Investing in Family Support Workshop October 2007, sponsored by the National Center for Hearing Assessment and Management (NCHAM). Parents play an active role in the development of new born hearing guidelines for hospitals, audiologists and early intervention. In recent months parents were able to promote and successfully obtain passage of newborn hearing legislation. The new law (Claire's Law") is named after the daughter of a very dedicated and involved parent.

Families and parents of children with hearing loss continue to be a priority for the Newborn Hearing Screening (NHS) program. Karen Dockery, parent of a child with hearing loss, continues to serve as the NHS Parent Consultant to assist with the development of family friendly educational materials and participate in the development and implementation of program policies, protocols, and in-services. She contacts individual families for support, works closely with parents of infants and toddlers with hearing loss to present their personal stories on several parent

panels, and chairs the NHS Task Force Parent Committee. NHS works in collaboration with TN-Family Voices and the three Family to Family (F2F) consultants who are located in each of the three grand regions of Tennessee. The F2F staff provide family support to individual families and facilitate linking families with families that have children with similar disabilities, including hearing loss. A new hearing parent support group was formed in the Knoxville area. Families participate in the distribution of education material to hospitals, provider offices and health fairs. They have been excellent advocates. Two parents of children with hearing loss attended the March 2005 HRSA/CDC EHDI National Conference.

An attachment is included in this section.

E. State Agency Coordination

E. State Agency Coordination

Maternal and Child Health and Women's Health staff at the central office, regional offices, and local health department levels are involved in numerous collaborative efforts within the Department with various programs, with other governmental departments and agencies, and with organizations and agencies outside government (universities, school systems, city/county government, hospitals, and nonprofit agencies such as March of Dimes, American Cancer Society, American Heart Association, and the Arthritis Foundation, Tennessee Suicide Prevention Network, State Minority Health Task Force, and the Council for Developmental Disabilities).

MCH has always had a strong collaborative relationship with metropolitan health departments in the state. Since these entities have separate boards of health, the state's role is to provide needed service, focused funding, training and continuing education and participation as a partner in all planning and system change initiated to improve the public's health. The six designated metro health departments receive funds through the state's contractual system. Staff in Metro Health Departments who provide MCH services are regularly included in conference calls, quarterly meetings, in-service training and planning meetings about MCH programs and services. Metro Regional Directors participate as active partners with rural Regional Directors in public health planning and new initiatives. The primary difference between these two entities is that metros report to boards of health and the mayor, while rural regional directors report to the Acting Assistant Commissioner, Bureau of Health Services Administration.

TennCare/Medicaid: The Childhood Lead Poisoning Prevention Program has a cost-sharing protocol with TennCare for cases when an environmental investigation is conducted for a lead poisoned child on Medicaid. Project TEACH staff work with TennCare, Managed Care and Behavioral Health Organizations and providers, and the Department of Education in providing medically necessary services to children enrolled in local school systems, including coordination of services and providing outreach to the child's family, encouraging them to access appropriate TennCare services. CSS requires that all children applying for the CSS program apply for TennCare; assists families in locating a medical home, specialists and related service providers within the MCOs' provider networks; keeps TennCare informed of underserved areas and works with the MCOs to identify out-of-network providers for CYSHCN. CSS participates in TennCare advocates' meetings to keep informed of changes and uses the network of state, regional, and local CSS staff for disseminating information. This route also allows direct CSS staff and parent interaction to ensure parent understanding of the changes and improve transition of services. CSS also helps families file appeals for denied medically necessary services. All local health departments are providing outreach, advocacy, and EPSDT screenings for TennCare enrollees.

The Newborn Genetic/Metabolic Screening and Hearing Screening programs provided training to the TennCare Managed Care Organization EPSDT Coordinators on screening requirements,

confirmatory diagnostic testing and follow-up systems.

Department of Children's Services (DCS): This agency is responsible for the children in state custody. The Department of Health is providing the EPSDT screenings for all these children. Other collaborations with DCS include funding for both the Healthy Start and Child Health and Development home visiting programs. MCH gets referrals from DCS and makes home visits to the family. Also, DCS staff are involved on teams reviewing cases for the Child Fatality Review program. MCH staff is invited to attend the multidisciplinary teams to case manage clients. CSS regional coordinators and Project TEACH staff work with the DCS Regional Health Unit nurses to coordinate health services for CYSHCN in state custody.

/2009/ In August 2007, Dr. Pinnock became secretary of the DCS Advisory Committe to the Commissioner.//2009//.

MCH staff are members of the Children's Justice Task Force, and the Child Sex Abuse Task Force, whose members are from many state government departments and community organizations. The Children's Justice Task Force, a multidisciplinary group of professionals and advocates focused on the welfare of children reported to have been abused or neglected, is charged with identifying existing problems and recommending solutions to DCS regarding the investigation and prosecution of child abuse and neglect. The Child Sex Abuse Task Force, a multidisciplinary group of professionals and advocates, is responsible for developing a plan of action for better coordination and integration of the goals, activities and funding of the Department of Children's Services pertaining to the detection, intervention, prevention and treatment of child sexual abuse.

Department of Human Services (DHS): The local health departments receive referrals from DHS as part of the Families First welfare program. Families that terminate the program are referred to the Department (DOH) for home visits in an effort to ensure that families will survive adequately without the Families First funds. The DOH home visitors assess the families, refer them to any needed services and submit reports to DHS. DHS houses the Division of Vocational Rehabilitation, TN Services for the Blind and Visually Impaired and the TN Technology Access Project. These programs work in collaboration with the CSS program. The Deaf/Blind Coordinator has participated on the Newborn Hearing Screening (NHS) Task Force since 1997. DHS offices currently serve as the place of application for Medicaid and TennCare. DHS provides CSS proof that CSS applicants have applied to TennCare. MCH has collaborated with DHS since 1996 to build a statewide network of child care resource centers which include a child care health consultant. Services provided include: technical assistance and consultation, training, and lending resource library materials and are available to all child care providers in the State. In addition, MCH through its Early Childhood Comprehensive Systems Program and its Child Care Resource Centers assist DHS in providing technical assistance for state regulated day care centers.
/2009/ In 2007- 2008, MCH has enhance its services to DHS by providing collaborative support to prevent childhood obesity and promote good social emotional development in child care populations. //2009//.

Department of Education (DOE): The directors of adolescent health and school health serve on the advisory committee of the Coordinated School Health Pilot (CSHP) Program. Staff are working with the CSHP director to plan school-based child obesity prevention programs in conjunction with the LeBonheur Hospital school health team in Memphis. In 2006, DOE and MCH continued their joint five year CDC grant to expand coordinated school health programs throughout the state. For FY 2006-07, they will be conducting meetings with educational stakeholders to promote the development of more coordinated school health programs, revising the State's Wellness and Physical Activity Plan. In addition, The MCH director currently serves on the recently established Early Pre-K Education Committee, which is currently restructuring policy for the State's early pre-K programs.

See paragraph under TennCare related to Project TEACH. The Department of Education,

Division of Special Education, is the lead agency for the IDEA Part C, TN Early Intervention System (TEIS) for infants and toddlers birth to 3 years old identified with or having a potential for a developmental delay. TEIS has been an active participant in collaboration with the CSS program since 1990. The programs coordinate referral and care coordination activities on infants and children requiring services from both agencies. An MCH staff person serves on the State IDEA Interagency Coordinating Council representing all MCH programs. TEIS staff serve on the NHS Task Force and the genetics implementation grant committee and have participated in joint in-services with CSS and NHS. The Tennessee Infant Parent Services (TIPS) program trains Parent Advisors to provide home-based services to infants and toddlers birth to 5 years identified with a vision and/or hearing loss, or other disability. TIPS and TEIS work closely with the NHS program and provide tracking, follow-up and intervention services for infants referred for or identified with a hearing loss after hospital hearing screening. The TEIS data collection system documents hearing follow-up and will link to NHS. An MCH staff serve on the Part C (Early Intervention) Monitoring Review Committee. CSS central office and regional office staff participate in Early Intervention Administrators' Forums which include various agencies and promote interagency linkages at the program administrators' level. Local CSS staff participate in meetings for individual CYSHCN with DOE Part C and Part B personnel in developing coordinated care plans to insure the coordination of services. CSS staff keeps DOE staff, including school health nurses, informed of TennCare changes to insure continuity of care. In 2006, TEIS is currently being evaluated and restructured to provide more effective services. The Commissioner and MCH Director are integrally involved in this process.

Head Start: A staff person representing Head Start and Early Head Start is an active member of the TEIS State Interagency Coordinating Council; MCH works through this committee with Head Start. The DOE Head Start Collaboration Officer is a member of the Childhood Lead Poisoning Prevention Program and the Early Childhood Comprehensive Systems Advisory Committees. These committees include state agency staff and advocates for children and meet regularly for discussion, information sharing and program policy coordination. The Director, along with Head Start health specialists and regional directors, have been invited to attend the MCH video-conferences to learn more about MCH programs and current diagnosis and treatment of conditions affecting children.

Mental Health/Developmental Disabilities: Staff are active members of the Child Fatality Review program at both local and state levels. MCH staff work collaboratively with the Department of Mental Health/Developmental Disabilities (TDMHDD) to assure that appropriate mental health services are accessed for children with special health care needs. Staff from Mental Health and their contracting agencies provide training for Project TEACH staff. The MCH Director serves on the Council on Developmental Disabilities. CSS includes an assessment of a child's psychosocial development and refers CYSHCN and family members to local mental health centers or other local MH providers if appropriate. Mental health and social-emotional development are one of the five critical areas being addressed in the Early Childhood Comprehensive Systems, and TDMHDD staff participate on the Advisory Committee. Currently, the MCH director serves on a statewide committee to develop a mental health system of care. MCH's Adolescent Health Program Director is currently assisting in implementing a suicide prevention training grant recently received by TMHDD.

The adolescent health director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state advisory committee composed of members from the private and public sector to prevent suicide. The director co-chaired a subcommittee to address youth suicide prevention. The committee developed a state plan to address youth suicide prevention.

Social Security Administration (SSA): MCH staff provide information on MCH programs to parents of CYSHCN who have applied for SSI. The CSS program coordinates referral of children whose names are received from the SSA. The parent or guardian is sent information about possible services available to their child from state programs (CSS, Mental Health, Mental Retardation,

TEIS, and the regional genetics centers).

Tennessee Bureau of Investigation (TBI): TBI staff are active members of the Child Fatality Review program at both local and state levels. CSS staff work with Corrections staff to get wheelchair ramps and custom made furniture for CYSHCN constructed at no cost to families. The MCH director is currently serving on a TBI led task force on Methamphetamine's impact on children.

Vocational Rehabilitation: See Department of Human Services.

The Commission on National and Community Service coordinates state volunteer efforts. The adolescent health director represents the Department of Health on this commission. Members include representatives from the public and private sector who are engaged in promoting volunteer services throughout Tennessee. This MCH staff person has assisted commission members and staff as they explore the feasibility of Tennessee becoming a "State of Promise" through the America's Promise initiative.

Child Fatality Review: The Child Fatality Review process is a statewide network of multi-discipline, multi-agency teams in the 31 judicial districts in Tennessee to review all deaths of children 17 years of age or younger. Members of the local teams include: Department of Health regional health officer; Department of Human Services social services supervisor; Medical Examiner; prosecuting attorney appointed by the District Attorney General; local law enforcement officer; mental health professional; pediatrician or family practice physician; emergency medical services provider or firefighter; juvenile court representative; and representatives of other community agencies serving children. Members of the State Child Fatality team include: Department of Health commissioner; Attorney General; Department of Human Services commissioner; Tennessee Bureau of Investigation director; physician (nominated by Tennessee Medical Association); physician credentialed in forensic pathology; Department of Mental Health and Developmental Disabilities commissioner; judiciary member nominated by the Supreme Court Chief Justice; Tennessee Commission on Children and Youth chairperson; two members of the Senate; and two members of the House of Representatives.
/2009/ A representative from the Department of Education was legislatively added to the State team. //2009//.

Childhood Lead Poisoning Prevention Program: Collaborating agencies include: a) University of Tennessee Agricultural Extension Service which provides social marketing to develop and distribute information on childhood lead poisoning to health departments and extension agents, and surveillance system assistance to analyze child blood lead level data and assist staff, partners and health care providers regarding medical case-management of children with elevated levels; and b) Tennessee Department of Environment and Conservation to conduct environmental investigations.

Adolescent Health: The adolescent health director serves on the Tennessee Healthy Weight Network. This network represents a public/private partnership of over 30 state and private organizations committed to addressing the obesity epidemic within Tennessee.

Federally Qualified Health Centers: Community Health Centers are located in medically underserved areas of the state. There are twenty-three Federally Qualified Health Centers (FQHC) that operate eighty nine clinic sites in Tennessee. These community health centers, which provide primary health care, dental and mental health services to more than 200,000 patients who became a part of the "safety net" to help those disenrolled from TennCare. Referral systems exist between those community health centers and health departments located within the same county.

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT): Since July 2001, local health department clinics have assisted TennCare by providing EPSDT screenings to TennCare

enrollees. The TennCare Program had difficulty in achieving desired EPSDT screening rates and is partnering with the Department to improve these rates. A Bureau of Health Services representative meets monthly with two groups in TennCare: (1) the EPSDT Workgroup comprised of representatives from all the managed care organizations; and (2) the Tennessee Chapter of the American Academy of Pediatrics representatives.

Folic Acid Education Campaign: Women's Health and Nutrition staff (central and regional offices) are partnering with the March of Dimes, Girl Scouts, and members of the state folic acid council to educate the citizens of Tennessee on the need for folic acid. Central office staff developed and implemented many of the statewide activities. The state folic acid coordinator serves as chair of the state council. The Women's Health director serves on the state council.

HIV/AIDS/STD: There is strong collaboration between the staff of the Women's Health and HIV/AIDS/STD sections. Family planning staffs make referrals for HIV counseling and testing and educate clients regarding all STDs including HIV/AIDS. With the integration of services at the local levels and the multiple functions performed by staff in the clinics, staff are very familiar with Women's Health and HIV/AIDS/STD programs. The Infertility Program (screening for chlamydia, treatment, and data analysis) is a joint project of Family Planning, STD, and the State Laboratory.

The Tennessee Breast and Cervical Cancer Early Detection Program (TBCCEDP): Seeking to educate women in Tennessee about the need for cancer screening, TBCCEDP coalition, consisting of private and public providers and advocates, meets twice a year to prioritize needs and seek solutions; central office Women's Health nursing consultant participates in these meetings. Regional MCH staff work closely with TBCCSDP coordinators.

Office of Nursing: MCH and Women's Health central office nursing staff routinely provide program updates at their quarterly statewide Nursing Directors' meetings. They also serve as consultants to answer health questions related to their respective programs i.e., Family Planning, SIDS, Lead Poisoning Prevention, Home Visiting, etc.

Health Promotion and Nutrition/WIC: Collaborative efforts among MCH and Women's Health staff, Health Promotion, and Nutrition/WIC, as well as partnerships with March of Dimes and other outside agencies on activities addressing prevention of smoking in pregnant women include advertising the availability of the national QUITLINE sponsored by the American Legacy Foundation and other educational activities. CSS makes direct referrals to WIC on all clients under 5 or mothers of CYSHCN who are pregnant. CSS purchases special formula if they need amounts above the allowed allocations under the WIC program. CSS also assists in obtaining special foods for PKU children.

Office of Policy, Planning and Assessment: Central office staff collaborate with the Health Statistics section on dissemination of annual releases of health data and special reports, collection of data through the joint Annual Report of Hospitals, collection of data for the Region IV Women and Infant Health Data Indicators Project, and in other MCH data projects. Women's Health staff are coordinating with this office on upgrading the newborn hearing screening data system. MCH and this Office will collaborate to implement the SSDI 2006-2011 grant.

Tennessee Adolescent Pregnancy Prevention Program: TAPPP councils operate in four of the six metropolitan areas and in multi-county groupings in the seven rural regions. The 11 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships are broadly representative of the surrounding community, and include Girl Scouts, March of Dimes, Department of Human Services, Department of Children's Services, community-based youth serving organizations, hospitals, local businesses, schools, universities, adoption service agencies, faith-based organizations, juvenile justice agencies, media representatives, and regional and local health councils. Each council participates in a wide range of activities, depending on local priorities and resources, including conferences, parenting and adolescent heath fairs, workshops, legislative briefings, and training

for professionals.

Tennessee Primary Care Association (TPCA): Department staff work closely with the TPCA primarily through the Office of Health Access, Regional and Local Health Councils, and the Women's Health Advisory Committee.

Other federal grant programs under the administration of the Department, such as WIC, Family Planning, lead and Newborn Hearing Screening, are discussed in other sections.
/2009/The CISS grant and the Abstinence Education only program have been eliminated. //2009//.

Identification of pregnant women and infants eligible for Medicaid: All local health department clinics provide pregnancy testing and presumptive eligibility for Medicaid. If presumed eligible, client data are entered directly into the TennCare database at the local health department site. Women's Health staff answer the toll-free number (Baby Line) which provides information and referrals for prenatal care. Pregnant women enrolled under presumptive eligibility are referred to DHS for further enrollment beyond the presumptive time period. Also, TeNNdercare Nursing call center answer the Live to 1 toll-free number set up to answer questions from citizens concerning the reduction of infant mortality.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	39.0	58.6	28.9	28.9	29.0
Numerator	1508	2288	1366	1366	1155
Denominator	386315	390312	473085	473085	398283
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data source is Hospital Discharge Tennessee resident only and population estimates

Notes - 2006
Data source is Hospital Discharge Tennessee resident only and population estimates

Notes - 2005
Data source is State of Tennessee Health Statistics. (Hospital Discharge Data)

Narrative:
Narrative:

The Bureau of TennCare has recognized asthma as being a high cost diagnosis through the managed care system. As a result of a TennCare Asthma Summit with representatives from all Managed Care Organizations (MCOs), recommendations were made on addressing asthma. Those recommendations were published in an Asthma Care Management Program, including quality improvement measures and provider and client educational materials. All are available to providers on-line. ***/2009/ In 2008, legislation was passed which called for the development of a comprehensive State plan. In addition, the Department of Health published a report on the burden of asthma in the State. //2009//***.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	62.0	77.5	66.8	62.9	83.6
Numerator	28443	38116	52414	53033	47264
Denominator	45876	49159	78503	84277	56537
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
State of Tennessee TennCare (Medicaid) database

Notes - 2006
State of Tennessee TennCare (medicaid) database

Notes - 2005
Actual medicaid data was not obtainable.
Data source is State's EPSDT database.

Narrative:
#2.Health Systems Capacity INDICATOR- percent of Medicaid enrollees less than one year of age who received at least one initial screen: The state's emphasis on EPSDT screening for all TennCare children is discussed in various sections of this document. (See Agency capacity, NPM #13, NPM #14, and SPM #7) The Community Outreach initiative and Call Centers should increase the number of screenings.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	0	0.0	0.0	0.0	100.0
Numerator		0	0	0	153
Denominator		1	1	1	153

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data source is the State of Tennessee CoverKids database.
All children are enrolled as medicaid eligible or uninsurable under the TennCare program.
Tennessee SCHIP, cover kids started enrollment in March 2007. This data is based on well baby visits according to the periodicity schedule issued from the American Academy of Pediatrics. Our population of babies less than 1 year of age was small and the percentage over 100% signifies that some babies had more than 1 well baby visits in that time frame.
This data is estimated.

Notes - 2006
Tennessee does not have a separate SCHIP program and N/A data reported. All children are enrolled as medicaid eligible or uninsurable under the TennCare program.
Tennessee SCHIP, cover kids started enrollment in March 2007 and currently no data is available.

Notes - 2005
Tennessee does not have a separate SCHIP program and N/A the data reported.
All children are enrolled as medicaid eligible, uninsured or uninsurable under the TennCare program.

Narrative:
#3.Health Systems Capacity Indicator- Percent of State Children's Health Insurance Program (SCHIP) enrollees less than one year of age who received at least one periodic screen: The state does not designate a TennCare enrollees as SCHIP or TennCare. All are considered to be TennCare enrollees.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	78.5	78.5	74.1	76.8	83.8
Numerator	61564	61783	60360	64738	72498
Denominator	78433	78696	81454	84277	86558
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data source is Tennessee Birthmaster file resident only

Notes - 2006
Data source is Tennessee Birthmaster file resident only

Notes - 2005
State of Tennessee vital records.

Narrative:
#4.Health Systems Capacity Indicator- Prenatal visits using the Kotelchuck index: Information on the state's activities and programs addressing the needs of pregnant women is included in Agency Capacity, Other Program Activities, and NPM #8, 15, and 18.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	100.0	100.0	100.0	100.0	80.0
Numerator	782057	775232	758628	743387	651564
Denominator	782057	775232	758628	743387	814643
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data source is State of Tennessee TennCare (medicaid) data based on eligibility.

Notes - 2006
Data source is State of Tennessee TennCare (medicaid) data based on eligibility. Data is based on estimation

Notes - 2005
Data source is State medicaid data based on eligibility.

Narrative:
#7.Health Systems Capacity Indicator- EPSDT eligible children ages 6 to 9 who have received any dental services during the year: Dental services for children are described in NPM #9 and I Agency Capacity. The number of children on TennCare ages 6 to 9 eligible for EPSDT services and receiving dental services increased significantly from June 2003 (54,648) to June 2004(63,239) to June 2005 (72,563).

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	43.7	51.4	60.4	37.0	39.1

Numerator	63239	72563	86569	56418	58912
Denominator	144621	141136	143367	152680	150683
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data source is State of Tennessee TennCare (medicaid) data based on eligibility. Data is based on estimation

Notes - 2006
State of Tennessee EPSDT database.

Notes - 2005
State of Tennessee EPSDT database.

Narrative:
#7.Health Systems Capacity Indicator- Dental services for children are described in NPM #9 and Agency Capacity. The number of children on TennCare ages 6 to 9 eligible for EPSDT services and receiving dental services increased significantly from June 2003 (54,648) to June 2004(63,239) to June 2005 (72,563).

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	100.0	100.0	100.0	100.0	9.0
Numerator	18909	19097	19781	22392	1962
Denominator	18909	19097	19781	22392	21881
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data source is the State CSS data and Federal progam data of State SSI recipients.
Data is based on true number receiving services vs. number offerred services as we have reported in previous years.
There is change in data methodology since the data was taken from a combination of the State's PTBMIS and the Federal program SSI database. The Numerator are from the State's PTBMIS database and Denominator are from the Federal SSI database. All numbers are for year 2007.

Notes - 2006
Data source is the State CSHCN, medicaid and SSI program

Notes - 2005
Data source is the State CSHCN, medicaid and SSI program

Narrative:
#8.Health Systems Capacity Indicator- SSI beneficiaries less than 16 in the state receiving services from the children with Children with Special Health Needs Program: All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available to them. Forty-one percent of the 5,570 CSS enrollees have SSI (FY2007). Program staff continue to contact families with newly diagnosed children and provide information on services available. Data for 2007 show that there were 23,665 SSI recipients in the state. All were contacted by CSS staff.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	matching data files	11.3	0	9.2

Notes - 2009
Different data source and Data on non medicaid population are not available.State Vital Records: Linked Birth certificate and medicaid files.
Data may be based on estimates

Narrative:
#5.Health Systems capacity Indicator- comparison of health system indicators for Medicaid, non-Medicaid, and total populations: Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index for the TennCare enrollees. Comparisons of the other three data elements consistently show that the total population has lower low birth weight and infant mortality rates and higher percentage of pregnant women entering prenatal care in the first trimester than the Medicaid group of women. Data over the past eight years from TennCare show that the TennCare program continues to improve the health status of women in Tennessee. The overall declines in low birth weight and in infant mortality in the TennCare population are indicative of improved outcomes in the management and care of women of childbearing age.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

Infant deaths per 1,000 live births	2007	matching data files	11.2	0	9.4

Notes - 2009
Different data source and Data on non medicaid population are not available.State Vital Records: Linked Birth certificate and medicaid files.
Data may be based on estimates

Narrative:
#5.Health Systems capacity Indicator- comparison of health system indicators for Medicaid, non-Medicaid, and total populations: Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index for the TennCare enrollees. Comparisons of the other three data elements consistently show that the total population has lower low birth weight and infant mortality rates and higher percentage of pregnant women entering prenatal care in the first trimester than the Medicaid group of women. Data over the past eight years from TennCare show that the TennCare program continues to improve the health status of women in Tennessee. The overall declines in low birth weight and in infant mortality in the TennCare population are indicative of improved outcomes in the management and care of women of childbearing age.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	76	0	85

Notes - 2009
Different data source and Data on non medicaid population are not available.State Vital Records: Linked Birth certificate and medicaid files.
Data may be based on estimates

Narrative:
#5.Health Systems capacity Indicator- comparison of health system indicators for Medicaid, non-Medicaid, and total populations: Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index for the TennCare enrollees. Comparisons of the other three data elements consistently show that the total population has lower low birth weight and infant mortality rates and higher percentage of pregnant women entering prenatal care in the first trimester than the Medicaid group of women. Data over the past eight years from TennCare show that the TennCare program continues to improve the health status of women in Tennessee. The overall declines in low birth weight and in infant mortality in the TennCare population are indicative of improved outcomes in the management and care of women of childbearing age.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	0	0	74.1

Notes - 2009
The Kotelchuck index is not calculated on the Medicaid data. Data on the Medicaid and non Medicaid population are unavailable . State Vital records :Linked Birth certificate and Medicaid file. Data is based on estimates.

Narrative:
#5.Health Systems capacity Indicator- comparison of health system indicators for Medicaid, non-Medicaid, and total populations: Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index for the TennCare enrollees. Comparisons of the other three data elements consistently show that the total population has lower low birth weight and infant mortality rates and higher percentage of pregnant women entering prenatal care in the first trimester than the Medicaid group of women. Data over the past eight years from TennCare show that the TennCare program continues to improve the health status of women in Tennessee. The overall declines in low birth weight and in infant mortality in the TennCare population are indicative of improved outcomes in the management and care of women of childbearing age.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	185

Notes - 2009
Data is TennCare file (Medicaid)

Notes - 2009
Data is TennCare file (Medicaid)

Narrative:
#6.Health Systems Capacity Indicator- Poverty level eligibility for Medicaid and for SCHIP: The state does not differentiate between the two categories. Medicaid coverage in Tennessee continues to include: SSI eligibles, TANF eligibles, medically needy eligibles, and pregnant women and infants under age 1 up to 185% of poverty, children from 1 to 6 at 133% of poverty, and children from 6 to 19 at 100% of poverty.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2007	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2007	 133 100

Notes - 2009
Data is TennCare file (Medicaid)

Notes - 2009
Data is TennCare file (Medicaid)

Narrative:
#6.Health Systems Capacity Indicator- Poverty level eligibility for Medicaid and for SCHIP: The state does not differentiate between the two categories. Medicaid coverage in Tennessee continues to include: SSI eligibles, TANF eligibles, medically needy eligibles, and pregnant women and infants under age 1 up to 185% of poverty, children from 1 to 6 at 133% of poverty, and children from 6 to 19 at 100% of poverty.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2007	185

Notes - 2009

Data is TennCare file (Medicaid)
Data is TN. Birth certificate and Tenncare file (Medicaid)

Notes - 2009
Data is TN. Birth certificate and TennCare file (Medicaid)

Narrative:
#6.Health Systems Capacity Indicator- Poverty level eligibility for Medicaid and for SCHIP: The state does not differentiate between the two categories. Medicaid coverage in Tennessee continues to include: SSI eligibles, TANF eligibles, medically needy eligibles, and pregnant women and infants under age 1 up to 185% of poverty, children from 1 to 6 at 133% of poverty, and children from 6 to 19 at 100% of poverty.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	No

Notes - 2009

Narrative:

#9.(A) Health Systems capacity Indicator- Ability of states to assure that the MCH program and Title V agency have access to policy and program relevant information and data: Within the Department of Health, support functions such as data set development, data analysis, and research are located in the Office of Policy, Planning, and Assessment (PPA). This Office houses a number of data sets which are either maintained by their staff or extracted regularly from other data systems. The state began collecting data for the CDC funded Pregnancy Risk Assessment Monitoring System (PRAMS) in May 2007. This new system is housed in PPA. WIC files are a component of PTBMIS. MCH staff have access to the output data within the PTBMIS files through a system of CUBES which is maintained by the Bureau of Health Services. Staff in the Bureau of Health Services. and the Office of Policy, Planning, and Assessment are available to MCH for assistance. Data for newborn metabolic and hearing screening are handled through the Neometrics system for Women's Health/Genetics and the State Laboratory.

Sections such as MCH do not have direct access to data, but have access through PPA or the Bureau of Health Services (HAS). The PPA staff epidemiologist assigned to MCH works with the section to provide data necessary, to improve the quality and quantity of data sets available, and to develop the interest and commitment to address state health status issues through specific studies of data. The staff in HAS provide data and support to MCH staff for the PTBMIS data system.

Tennessee participates in the Youth Risk Behavior Surveillance System (YRBS). The survey is administered by the Department of Education every two years. The data results are available to MCH staff. The adolescent health director works closely with the staff in the Department of Education on these data and programs of mutual concern. Tennessee does not administer the Middle School YRBS survey. In order to plan more effective policy and determine more effective programming for Tennessee's middle school population, data from this group are needed. The data is used to develop and update the State's first Adolescent Report which was published in 2006 and has biannual updates.

The Genetics and Newborn Metabolic and Hearing Screening Programs use propriety software from Neometrics to manage program data. The Case Management System contains data on all abnormal metabolic screening results, demographics on the infants, and information on follow-up and treatment. The system generates a letter to both the parents and the primary care provider to repeat the specimen. The system allows tracking of each hospital's rate of unsatisfactory specimens. At this time, the data are not being linked to the birth files. On January 1, 2004, a field was added to the birth certificate for the specimen kit control number. It is expected that the 2005 data will be able to be linked.

The Tennessee Birth Defects Registry (TDBR) is a system housed within PPA. An annual report of Tennessee Birth Defects 2000-2002 was completed. The TBDR initiated a program that involves sending public health nurses to selected nurses to selected hospitals to review infant medical records. The active review of medical records provides a depth of information not available through other passive sources (e.g. birth files and hospital discharge information). The TBDR is working toward adding birth defects information to the Department's web site.

Tennessee counts for the five year period 1999-2004 are: anecephalus 61 cases, and spina bifida 173 cases. The TBDR data are the combined product of passive surveillance based on hospital discharge records and active medical records reviews conducted by public health nurses. TBDR birth defects data will be added to the interactive data query website, Health Information Tennessee in late 2008.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state	Does your MCH program have direct

	participate in the YRBS survey? (Select 1 - 3)	access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Pediatric Nutrition Surveillance (PedNSS)	3	No
WIC program Data	3	No

Notes - 2009

Narrative:
#9.(B) Health Systems Capacity Indicator- Percent of adolescents in grades 9 through 12 who report using tobacco products in the past month: This indicator is SPM #3. Data are obtained from the Youth Risk Behavior Surveillance System and available every two years. The survey is the responsibility of the Department of Education. The data results are available to MCH and staff through the close working relations of the adolescent health director in MCH and staff in the Department of Education. In addition, the Tennessee Youth Tobacco Survey provides information on use of tobacco products by youth.

IV. Priorities, Performance and Program Activities
A. Background and Overview
A. Background and Overview

The federal government and Tennessee partner to improve services and activities for the MCH populations in need. The process of developing a needs assessment, planning, designing and implementing programs, and allocating resources is a critical part of the public health system in Tennessee. Tennessee continues to address its priority areas as determined through last year's Needs Assessment.

Tennessee has made every effort to directly tie the priority needs of the state and the national and state performance measures to the capacity and resource capability of MCH at the local, regional and central office levels. The direct health care services offered through the public health system are in response to identified needs and gaps in service for women, infants and children. The primary emphasis of all health department activity is to assure that women, infants, and children receive the preventive care they need to reduce morbidity and mortality. In response to the changes in the TennCare program, primary care capacity has been expanded inthe Department of Health by 100%.

Local health departments, especially in rural areas, continue to provide direct health care services for women, infants and children. Pregnancy testing, sexually transmitted disease screening, HIV counseling and testing, and family planning services are available in every county. All counties operate WIC and nutrition services. Individual and population-based health education about the continuing and emerging health care needs of women is readily available. Infants and children can receive immunizations and well child screenings in compliance with EPSDT. These examinations include blood lead level screening in compliance with the Child Health Manual standards and EPSDT guidelines. Local health department staff follow-up with all children having elevated blood lead levels through periodic monitoring, environmental and household inspection and lead abatement activities with the families.
/2009/ The Department received ten million dolars from the state and launched a tobacco cesstion program targeted at pregnant women and teens who smoked. All local health departments are participating in this initiative.//2009//.

For children and youth with special health care needs, local nurses assist the Genetics and Newborn Screening program when an infant residing in their county needs to be located for follow-up. Children enrolled in the CSS program can receive basic well child care at the county health department with MCO approval, and the CSS care coordinators are based in each county to assist families with needed medical and referral services.

Enabling services concentrate on access to care, care coordination, home visiting services, and newborn screening follow-up. Staff at the local, regional and central office levels continue to invest significant amounts of time assisting TennCare enrollees with complex TennCare issues. These TennCare activities include outreach and advocacy, determining presumptive eligibility for pregnant women and women with breast or cervical cancer, assistance with the appeals process, referring all CSS children for TennCare enrollment, and assuring that those presumptively eligible for prenatal care are receiving needed services. The care coordination component of CSS provides special support and enables families to better meet their child's needs in a complex health care environment. In addition, outreach activities will be expanded to address decreasing infant mortality.

/2009/ The Help Us Grow Successfully (HUGS) program expanded its workforce by 17 percent to help address infant mortality.//2009//.

Population based services are available through the activities of MCH, Women's Health, Nutrition,

Health Promotion and Communicable and Environmental Disease Sections of the Bureau. These services target groups of people rather than individuals. Examples include: newborn metabolic screening for all newborns; newborn hearing screening; surveillance for sexually transmitted diseases; adolescent health; childhood lead poisoning prevention program; the child fatality review system; SIDS counseling and autopsies; and adolescent pregnancy prevention program. Some services at this level of the pyramid are targeted at entire groups, such as the newborn screening program. Others take a population-based approach to surveillance, as in the case of persons with diagnosed STDs, and track contacts and provide treatment. Health education activities target even broader populations in hopes that repeated messages and information will result in positive lifestyle choices to prevent morbidity and mortality.

Tennessee's current infrastructure building activities concentrate on regional and county needs assessments, quality management, data and systems planning and the development or revision of standards and guidelines. Assessment for health planning is a statewide activity through the community health councils. Each county, and in turn each region, has developed a priority list of health needs based on data; groups develop and update implementation plans and activities to address these priorities on the local level. The Bureau has staff specifically assigned to develop and oversee the quality management (QM) structure which consists of local quality units, regional quality units and a state quality council. Regional quality teams facilitate and coordinate QM at regional and local levels. The data and systems planning functions have been greatly enhanced with the availability of SSDI funds which have been used to provide support for the statewide computer network.

Training of regional and local staff is a key role of the central office. In collaboration with Vanderbilt University's MIND (Mid-Tennessee Interdisciplinary Instruction in Neurodevelopmental Disabilities) Training Program, MCH continues to provide interactive training on MCH programs and health issues through video-conferencing statewide. MCH wanted to be assured that CSS and other health department staff were appropriately trained. Ten to twelve videoconferences are held each year addressing current information on specific diseases and conditions, along with the treatment or clinical applications. Topics addressed in 2005-06 were infant mortality, epilepsy, nutrition in CYSHCN, information technology resources and developmental assessment.

/2009/ Topics addressed in 2007-08 bioterrorism and individual preparedness, autism, ethics in home visiting, Fragile X, newborn screening, and FIMR/PRAMS information.//2009//.

B. State Priorities

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

B. State Priorities

In the 2005 Needs Assessment process, Tennessee established ten priority areas. Six of the areas remained priorities as they had been focused on during the FY 2000-2005 period. Four areas were new and reflected the Commissioner and Department of Health's direction, as well as direction from the governor.

The state's identified performance measures are listed as follows:
1. Increase percentage of children with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.
2. Reduce incidence of maltreatment of children younger than 18 (physical, sexual and emotional abuse, and neglect) to rate no more than 8 per 1000.
3. Reduce the number of babies born prematurely.
4. Reduce the number of pregnant women who smoke and use illicit drugs.
5. Reduce the number of overweight and obese children and adolescents.

6. Reduce the proportion of teens and young adults (ages 15-24) with Chlamydia Trachmomatis infections attending family planning clinics.
7. Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.
8. Reduce the number of high school students using tobacco. (cigarettes and smokeless)
9. Reduce the number of high school students using alcohol.
10. Increase the percentage of youth with special health care needs, age 14 and older, who receive formal plans to transition to adulthood.

Priority setting is a continual process. With the current Administration in place, the Department has started a new strategic planning process. The Governor outlined his priorities for State Government. Two of these directly relate to health department activities and services. The Governor strongly believes every child deserves to grow up healthy and happy. He wants the state to work with families, agencies and foster parents to help protect children. He created a Children's Cabinet to encourage better cooperation between health agencies and nonprofit agencies responsible for children's welfare, including TennCare and the departments of Children's Services, Education, and Health. In June 2004, the Governor created the Governor's Office of Children's Care Coordination (GOCCC) to coordinate the wide range of services and supports available to children through state departments and the private sector.

/2009 The GOCCC completed recommendations for a complete reform of the Tennessee Early Intervention System (TEIS: birth to 3 yr) that were accepted by DOE Commissioner Seivers. The GOCCC is directing the state's efforts to improve birth outcomes by issuing grants to implement evidence-based medical and social practices that will lead to better preconception, prenatal and post-natal care of mothers and infants and organizing communities to establish priorities and sustain on going efforts. The GOCCC is also working to develop the state's infrastructure to support evidence-based practices in multiple settings.

Several programs aimed to reduce infant mortality sponsored by the GOCCC showed promising results. ACentering Pregnancy projected yielded 32 out of 36 infants born at normal weight and without perinatal complications. A Tobbocco cessation program for pregnant mothers preliminarily showed a significant reduction in prenatal and postnatal smoking. Starting May 1, 2008, the GOCCC is collaborating with DOH and the State Board of Education (SBE) to improve well-child visits among the teenage population. SBE passed rules requiring all 7th and 9th grade athletes to acquire a complete well-child screen prior to participating in sports. Grade entry requirements in the middle and high schools for full screenings are under review.//***2009//.***

The Governor restructured TennCare benefits as the way to continue providing needed health services to many Tennesseans. Two priorities address management of state government. The Governor believes that the way to avoid a budget crisis is to change the way state government works. He has been examining state government from top to bottom to find savings and identify more efficient practices. He stated that strong management of state government begins with earning the taxpayer's trust, including establishing accountability in all state agencies.

In 2006, Governor Bredesen proposed his "Cover Tennessee" initiatives to offer affordable health care insurance to employees of small businesses; expanded the State's current SCHIP eligibility; and provide disease management services to persons with diabetes. The expansion of SCHIP may potentially double the current number of children eligible for such services.

/2009/ The Cover KIDS program began enrollmentin March 2007. See Overview//2009//.

In 2005-06, Governor Bredesen strongly supported education by increasing, teacher pay, increasing school district funding, doubling the capacity of his early pre-K program from 100 to

250 classrooms.

/2009/ In 2006-07 Governor Bredesen added 250 more pre-K classrooms. More classrooms were projected for the FY2007-08 year but were not funded due the the state funding crisis.//2009.

In light of a series of scandals involving public officials, Governor Bredesen promised strong ethics policies. He held a special session of the Legislature and issued several executive orders to support the establishment of such policies.

In 2004, the Governor and the Commissioner of Health issued a wake-up call to all Tennesseans to start living healthier and make more responsible health choices. The goal of the "Better Health: It's About Time!" initiative is to raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well-being, and to give newborn babies a better start in life. The initiative specifically targets infant mortality, prenatal care, adolescent pregnancy, cardiovascular disease, obesity, and diabetes, and also aims to eliminate racial and ethnic health disparities in these areas. The Department of Health is working on a number of efforts to address these problems, utilizing intradepartmental strategies to focus existing resources and programs on the targeted issues, as well as intra-governmental strategies to collaborate with other departments in state government. The Department is also forming new partnerships with non-governmental agencies, community-based organizations and the faith community. The Department of Health and all sections, including maternal and child health, are involved in the development of new strategic plans for programs and activities.

/2009/ Commissioner Cooper has continued the Governor's emphasis on physical fitness and diabetes. She brought the two programs: GetFitTN and Project Diabetes to the Department of Health. (see the overview section.//2009//.

/2009/ Tennessee General Assembly passed legislation to increase the state cigarette tax and the law went into effect July 1, 2007. With the leadership and support of the Commissioner of Health and assistance from CDC, the Tobacco Use Prevention and Control Program (TUPCP) prepared a budget improvement request for a Comprehensive state Tobacco Cessation Initiative to be implemented in FY 07-08. The Commissioner presented the request to the Governor during the department's budget hearing. The allocation to the Department was $10,000,000; $500,000 is to be used to sustain and enhance quitline systems and services and promotion, $1 million for youth initiation prevention, $1 million for community tobacco prevention programs and $6 million for NRT distribution thru local health departments. The TUPCP launched a QuitLine web page which is accessible from the Tennessee Department of Health's website and allows Department staff, community projects, internal and external partners to freely print information on the services provided by the QuitLine, access promotional print materials and best practice strategies for offering services and treating tobacco use and dependency.
TUPCP/TDH secured earned media promoting the QuitLine from more than 25 sources including television news stations, public radio, radio stations, talk radio shows medical center journals, health system web reports, press releases, national, state and local news papers and health professional publication.//2009//.

Detailed discussion of the national and state performance measures is included in parts C and D of this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	140	209	176	180	161
Denominator	140	209	176	180	161
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Data source is the Tennessee Department of Health.
Data source is the State of Tennessee STD infertility project data system
Data source is the state of Tennessee New Born Screening data system.
In 2007 the State started the PRAMS survey.

Notes - 2006
Data source is the state of Tennessee New Born Screening data system.
In 2007 the State started the PRAMS survey.
This data is based on estimation.

Notes - 2005
Data source is the state of Tennessee New Born Screening data system.
In 2007 the State may start the PRAMS survey.

a. Last Year's Accomplishments
The state's Genetics and Newborn Screening (NBS) Program was established in 1968 as a result of state legislation requiring PKU screening of all babies. The NBS Program has established a network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases. Close linkages also exist between the centers and Children's Special Services for referrals. An advisory committee guides program activities and recommends changes; this committee has been vital in expanding the screening panel. Genetics staff, located at the State Laboratory, are responsible for interfacing with the State Laboratory to identify, locate and follow up on newborns who have unsatisfactory or abnormal results from the mandated screening. Referrals are made to the genetics and sickle cell centers as well as pediatric endocrinologists. When an infant is identified as having a questionable specimen, the follow-up nurses contact the provider so that another specimen can be collected and sent to the State Laboratory or another means of confirmatory test can be done. Access to genetic screening, diagnostic testing and counseling services is available at three regional comprehensive genetic centers, two satellite Genetic Centers, five pediatric endocrinologists, two comprehensive sickle cell centers and two satellite sickle cell centers for individuals and families who have or who are at risk for genetic disorders. If needed, local health department nurses

assist in locating an infant needing follow-up.

This performance measure has been successfully met for many years due to the state law requiring testing of all infants born in the state and the quality and efficiency of the State Laboratory and the NBS follow-up program. As of September 2007, the State Laboratory was testing for all the diseases recommended by national organizations, including the March of Dimes, except for cystic fibrosis. Based on recommendations from the Genetics advisory Committee, the decision was made to begin screening for cystic fibrosis in FY 2008. A work group (Pediatric Pulmonologists, Genetics Advisory Committee (GAC) members, follow-up staff, and laboratory staff) was formed to assist with follow up and referral protocols and procedures and provider and parent materials.

The State Laboratory has continually monitored testing cut-off values to determine if changes need to be made based on the population of Tennesseans. The data collected are reviewed by the Genetics Advisory Committee (GAC) which includes the Genetic Centers Directors, Pediatric Endocrinologist, and others.

A newborn screening DVD was developed and dispersed to stakeholders in order to educate them about newborn screening testing, proper specimen collection and follow up protocols for abnormal and unsatisfactory results and referrals. Continuing education credits will be offered through the National Laboratory Training Network (NLTN) until September 2009 for nurses and lab technologists that take advantage of the training.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen all infants born in Tennessee for those diseases/metabolites determined by the Genetics Advisory Committee and the Department and state law.			X	
2. Follow-up on all infants needing a repeat test or further diagnostic work.	X	X		
3. Work closely with Genetic and Sickle Cell Centers on follow-up and treatment.	X	X		
4. Work closely with birthing facilities on improving the unsatisfactory rates, including distribution of the revised training CD, routine calls, and site visits.	X			X
5. Support the Genetics Advisory Committee.			X	X
6. Work closely with all birthing facilities and health care providers on newborn screening testing and results.	X			X
7. Provide educational materials for parents and providers on newborn screening tests.	X		X	
8. Assist with re-evaluation of cut-off values for testing.			X	
9.				
10.				

b. Current Activities

Effective April 1, 2008, the screening panel was expanded to include cystic fibrosis. The state currently screening for all diseases recommended by national organizations.

The NBS Follow-up Program is providing quarterly reports to all hospitals submitting specimens. The reports list the number of specimens submitted and the number which were unsatisfactory. Many of the hospitals are utilizing these reports for quality improvement and in-service training for staff that collect specimens.

The GAC, comprised of representatives from the genetic centers, pediatric endocrinologists, a hematologist, and a pediatrician/lawyer, met twice this year to guide the program and recommend changes in tests and test procedures to the Commissioner. There were many conference calls to discuss the implementation of cystic fibrosis screening. The make-up of the Committee is being reviewed to determine if additional members with additional expertise are needed.

The program continues to provide both parent and provider information on all the different metabolites and disorders. Extensive information is available on the Department of Health's web site. NBS follow-up staff are available to both providers and families to provide information.

c. Plan for the Coming Year

All previously described testing and follow-up services will continue. Education of health care providers will continue. Plans are to conduct onsite visits to selected hospitals for staff training.

Staff are researching potential recommendations on rescreening of very low birth weight babies in order to establish guidelines for collection and repeat collections for NICU infants. Survivability has continued to improve for increasingly smaller and more premature infants. NICU infants are at greater risk for missed or incomplete newborn screening due to focusing on the critical activities on their need for intensive care. The Perinatal Advisory Committee will be asked to assist with the development of guidelines for screening these infants.

Rules and regulations are being updated to include newly enacted legislation mandating newborn hearing screening and to define the role of the primary care provider in metabolic screening follow-up. New quality assurance efforts are underway in order to assess timely specimen transport and arrival in the lab for testing.

The Department of upgrading the Natus/Neometrics Inc. Metabolic Screening Data System (MSDS) and Case Management System (CMS) moving toward paperless case management. The system also includes interfacing the instruments in the lab so data generated will download to the MSDA and CMS system immediately. Reducing turn around time of results being reported and improving follow up.

The Genetics Advisory Committee will meet at least twice during the year to address ongoing newborn screening issues, advise the Department of Health on the direction of the screening and follow-up program, and provide recommendations for changes to the screening panel.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	94.5	96	70	62	62
Annual Indicator	59.3	59.3	59.3	60.0	60.7
Numerator	3703	3703	3703	3807	3381
Denominator	6244	6244	6244	6349	5570
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	62	62	62	62	62

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
Children's Special Services (CSS) has continued to work towards establishing the people and resources necessary to ensure success for transitioning children to adulthood. All "traditional" transitional partners have been contacted for working toward the transitional needs and all are very willing to assist in this project. CSS also made contact with those "non-traditional" transitional partners for their participation in this important transitional project. Some of those contacted include: private employers, recreation directors, mayors, council members and aldermen, religious leaders, retail and grocery store owners, transportation personnel, housing developers, as well as other community activist.

The Governor's Children's Cabinet, the Tennessee Council on Developmental Disabilities, The Tennessee Disability Coalition, Family Voices, and Child Health Policymakers continued to be important partners. This partnership included regularly scheduled meetings as well as participation in the CSS annual meeting to discuss CYSHCN needs for accessing services, prioritizing needs, and presenting them to policymakers to help determine legislative action. Priorities identified at this year's meeting included a need to have a child advisory board, transitions to adulthood, and cultural competence training especially with our growing Hispanic population.

Children enrolled in CSS and their families continued to participate in the development of a Family Service Plan (FSP). The FSP is an assessment tool from which a problems/needs list is developed. The assessment tool includes family medical and non-medical needs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner with groups who advocate and serve children and youth with special health care needs		X	X	
2. Have parents help develop the child's family services plan for each child enrolled in CSS.		X		
3. Include parents on the CSS Advisory Board.				X
4. Conduct annual parent satisfaction survey.			X	
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS has asked that an additional parent serve on the CSS Advisory Board. It has also been suggested that if approved the parent come from the Governor's Children's Cabinet. CSS staff continues to work with local and statewide groups on behalf of children served. Surveys will continue to be conducted with parents of children with special health care needs. Transitional services are a key point currently and will continue in the upcoming fiscal year and children and parents will be an active participant at all levels of decision making.

c. Plan for the Coming Year

During 2006-2007, CSS collaborated with Family Voices to conduct surveys of families with children with special health care needs. The survey questioned their involvement in the decision making process and their satisfaction with the services received. The results of the survey indicated that 92% of the respondents are involved in decision-making, and 89% are satisfied with the level of services received.

CSS and Family Voices will conduct town hall meetings and focus groups to discuss results of the survey with families, providers, and community agencies. A second statewide survey for children with special health care needs will be developed and disseminated. The results of this survey will be utilized as a guide for program staff to determine areas of focus or concern for CSHCN. CSS program staff will continue to educate families on interaction with medical providers concerning their involvement in making decisions for medical care while making a concerted effort to ensure satisfaction is achieved in each level of the process.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	94.5	96	75	63	64
Annual Indicator	60.0	60.0	60.0	60.7	52.7
Numerator	3746	3746	3746	3857	2935
Denominator	6244	6244	6244	6349	5570
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	65	65	65	65	65

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
CSS continued to ensure that all children with special health care needs received coordinated, ongoing, comprehensive care with a medical home. Care coordinators remained the consistent link between the family, the PCP, and other providers .

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide care coordination services to each enrolled child and his/her family.	X	X		
2. Assist families moving from or to other states and needing CYSHCN.		X		
3. Use the monitoring system to identify each child's medical home or the need for one.	X			X
4. Continue to educate local primary care providers on the medical home concept.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The CUBE reports continue to be monitored to ensure that all CSS eligible children receive services within the medical home. Program staff continue to update and educate local primary care providers concerning the necessity of the medical home as well as other local resources available. All program policies continue to be evaluated to make certain that coordinated, ongoing, comprehensive care within the medical home has been met. On-site monitoring of all CSS Metro Regional offices will be conducted to ensure that program policies and procedures are being met.

c. Plan for the Coming Year
CSS will conduct a face-to-face meeting with program staff statewide to update on policy and procedures, as well as continual development of the transitional services. CSS program staff will continue in its efforts to assist families in the identification of pediatric/family practitioners or specialist to provide coordinated ongoing comprehensive care within the medical home. Children 14-21 will have individualized transition plans whose implementation will assist in the preparation for transition from CSS and pediatric providers to adult providers and adult medical homes.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	94.5	96	75	64	64
Annual Indicator	62.0	62.0	62.0	61.4	67.7
Numerator	3871	3871	3871	3897	3771
Denominator	6244	6244	6244	6349	5570
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	69	69	69	70	70

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
CSS continued to update and educate families and providers concerning the latest insurance information available including TennCare coverage and Cover TN insurance programs. The state was given approval to proceed with reducing the number of enrollees receiving benefits from TennCare. The state also asked for approval for limiting the number and type of drugs presently part of TennCare benefits. This change has affected the CSS program significantly. Enrollment has increased, and it appears very likely the number of children needing to enroll in the CSS program will increase during the upcoming fiscal year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure that all children applying for CSS services also apply for TennCare or Cover TN products.		X		
2. Provide care coordination services to all CSS families statewide assisting families with access to medical care, utilization of services, transportation, etc.		X		

3. Work with TennCare, the managed care organizations, and providers to ensure service needs are met of this special population.		X		
4. Assist families with any needed appeals to TennCare for denied services.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS is experiencing an increase in the number of children being served due to the cuts in TennCare. This increase in enrollees forces CSS to become more involved in the direct medical care of the children served. Fiscally it is much more beneficial for CSS to direct its own medical clinics rather than have each eligible child separately visit a medical specialist. CSS will continue to educate families and providers concerning medical insurance information while continuing to require application for TennCare and other SCHIP benefits. Due to disenrollment of participants from TennCare and State Statute providing for coverage of cystic fibrosis participants until their demise, CSS currently provides benefits for 34 individuals over 21 years of age who have cystic fibrosis and limited or no medical insurance.

c. Plan for the Coming Year

CSS is expecting an increase in the number of children being served due to budgetary constraints that will prevent TennCare from expanding their medically needy enrollees. CSS is collaborating with Cover TN to develop mechanisms that will provide information and assistance in understanding requirements and applying for these benefits. CSS staff will be trained on all Cover TN products, and will provide this information to the families. CSS will continue to provide medical services as well as care coordination and will continue working with families educating them on all available public and private insurance options.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	94.5	96	90	82	82
Annual Indicator	80.0	80.0	80.0	80.8	91.8
Numerator	4995	4995	4995	5128	5113
Denominator	6244	6244	6244	6349	5570
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	93	93	93	93	93

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
CSS continued to identify needed services available within the community that are easily accessible. Staff worked closely with MCOs, insurance companies, and other providers for improving access to local services. Patient satisfaction surveys were conducted during regular clinic visits.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate CSS services with other health department services (i.e. scheduling access, etc.)		X		
2. Provide care coordination services, including referrals and linkages with community agencies, to all families participating in the program.		X		
3. Work with regional and local health councils to identify needs and gaps in services in specific communities.				X
4. Work with state agencies such as the Department of Mental Health/Developmental Disabilities, Education, and Mental Retardation, local mental health centers, and school systems to develop a system of care approach to services for the population.				X
5. Conduct annual parent satisfaction surveys.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSS will continue to identify those community-based resources that are easily accessible. In addition, CSS continues to collaborate with agencies to facilitate referral and access to CSS and partner agencies' services.

c. Plan for the Coming Year
CSS continues to identify and intensify their efforts with the TN Council on Developmental Disability, Tennessee Disability Pathfinder, Tennessee Technical Assistance & Resources for Enhancing Deafblind Supports (TREDS), TEIS, Tennessee Housing and Development Agency

(THDA), United Cerebral Palsy (UCP), and the Governor's Office of Child Care Coordination in an effort to provide CSS Clients with all eligible services and or resources.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	94.5	96	50	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1561	1561	1561	1561	1534
Denominator	1561	1561	1561	1561	1534
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. The increase in the annual indicator was due to wrong methodology previously used in counting the variables. The denominator entered previously were wrongly counted due to errors in count methodology. This has being corrected to show consistency for future years. Changes were made to our annual indicators as well.

a. Last Year's Accomplishments
CSS conducted training for all CSS program staff. CSS identified national transitional partners to conduct this training. Following the training, CSS staff had the resources necessary to create a statewide transitional plan that will be used as a model for all individual transition plans. CSS ordered the 411 on Disability Disclosure Workbook for Youth with Disabilities for distribution to all youth aged 14 and older.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Include transition services in the individual care plans for those clients approaching adulthood.	X	X		
2. Maintain listing of community referral resources.			X	X
3. Assist with all appropriate referrals for these clients.		X		
4. Train CSS staff on transition issues.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS is working at identifying each and every need a child and family will have concerning transition from adolescence to adulthood. CSS is developing a statewide transitional team as well as regional transitional teams and is identifying available as well as non-available transitional resources within the community. A resource guide to transitions has been developed that will be shared with all other agencies, private providers, advocacy groups, families, and any other entity interested in transitions to adulthood. CSS staff will continue to hold transitional training meetings across the state.

c. Plan for the Coming Year

CSS is in the process of developing a statewide transitional team and plans that can be utilized in the regional and metro areas. The team will be comprised of parents of children with special health care needs, CSS participants, staff and community agency representatives. A statewide meeting has been planned for July 2008 to standardize and enhance transitional services to the CSS participants. Field staff will be provided technical assistance by Healthy Ready to Work. Age appropriate transitional plans will be continue to be developed for all participants age 14 and older.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	90	94	95	81	83
Annual Indicator	78.4	77.2	79.1	86.7	86.7
Numerator	55881	60040	90761	1300	1300
Denominator	71277	77773	114731	1500	1500
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	88	88	88	89	89

Notes - 2007

The data reported in 2007 are pre-populated with the data from 2006 and the CDC Immunization survey and is based on survey sample size for this performance measure.

Notes - 2006
Data is from cdc.gov/nipcoverage/nis/05-06.
This data is from the cdc immunization survey and is base on survey sample size.
In 2005 full schedule of approperiate immunization was expanded.

Notes - 2005
Data is from NIS Data for Tennessee
In 2005 full schedule of approperiate immunization was expanded.

a. Last Year's Accomplishments
Tennessee measures immunization at age 24 months through its annual immunization survey. The survey is a statistically valid sample of the immunization status of two-year- old children that is statistically valid for each of the state's administrative districts. As previously mentioned, the criteria have base line has changed for this survey. The 2007 survey was comprised of 1470 children. The completion rate for the standard 4:3:1:3:3:1,
Series defined by the Centers for Disease Control and Prevention (CDC) in that survey was 82.4%. All health department staff have been trained to review the immunization status of any person presenting for any type of service at the clinics and provide needed immunizations, or assist with referrals to the PCP. The Department's contractual arrangement with TennCare to provide EPSDT exams has provided additional opportunities to provide immunizations and to check current status. The 2006-7 immunization rate for day care children who are in compliance with the immunization law is 92.8%.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide immunization in local health department clinics.	X			
2. Check immunization status of persons requesting any type of services at local health department clinics.	X			
3. Maintain and continue to improve the Immunization Registry software and capacity for electronic access for submission and retrieval of data.			X	X
4. Use intranet connection to increase data input by private physicians to Immunization Registry.			X	X
5. Access immunization coverage levels in the population.				X
6. Immunization staff continues to work with providers within their geographic areas providing technical assistance.			X	X
7.				
8.				
9.				
10.				

b. Current Activities
Current activities include: (1) identifying high-risk children and assure they are completing their immunization series; (2) performing formal assessments during site visits (known as "VFC/AFIX visits") to all providers enrolled in the VFC program to ensure efficient service delivery of vaccines to those for whom they are recommended; (3) expanding the availability of the immunization registry web site to private physicians offices; (4) conducting immunization level assessments in population sub groups such as day care enrollees and kindergarten students, identifying those at high risk of not completing immunizations and devising strategies to reach them; (5) conducting

follow-up on children born to hepatitis B surface antigen positive women to ensure receipt of HBIG and hepatitis B vaccine as recommended.

c. Plan for the Coming Year
The strategy will be much the same as this year. The major emphasis will be on the VFC/AFIX visits to the providers' offices to assure appropriate adequate use of vaccines. There will also be an emphasis on expanding the availability of the immunization registry web site and a new objective will be to increase the amount of private physician-administered vaccine doses that are reported to the immunization registry. Immunization level assessment activities will continue as well as the development of approaches to reach those less likely to complete immunizations on time. Follow-up of children born to hepatitis B surface antigen positive women will also continue.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	27	24	23	27	26.5
Annual Indicator	27.8	26.3	27.5	28.6	27.8
Numerator	3203	3057	3229	3389	3354
Denominator	115376	116426	117523	118599	120852
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	26.5	26	25	25	25

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2007 population estimates and the Tennessee Birth Master file for this performance measure.

Notes - 2006
Data is from Tennessee Birth Master files.
Data source is the State of Tennessee Health Statistics System.
The increase of 1.2 appears to be a trend that might happen in the U.S. (most states) and consistent with previous years.

Notes - 2005
Data source is the State of Tennessee Health Statistics System.
The increase of 1.2 appears to be a trend that might happen in the U.S. (most states) and consistent with previous years.

a. Last Year's Accomplishments
The Department of Health's Abstinence Education Program funded 16 community-based projects across the state. Projects were charged with providing abstinence until marriage, character, and life skills education and activities to youth 10-17. The Program reached over 35,000 youth directly, in addition to many of their parents and siblings.

The Director of the Abstinence Education Program collaborated with National Center for Youth Issues to collaborate the annual, statewide Celebrating with Healthy Choices for Youth Conference. Three hundred and thirty state employees, educators, counselors, youth service workers, and members of the faith based community attended. The conference provided current, pertinent, best practices for providing abstinence and overall youth development information, in addition to providing opportunities to network with others in the youth service/education fields.

Tennessee Adolescent Pregnancy Prevention Program (TAPPP) councils operated in four of the six metropolitan areas and in multi-county groupings in the seven rural regions. The 11 Coordinators served as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships are broadly representative of the surrounding community. Each council participates in a wide range of activities, depending on local priorities and resources.

Providing community education and awareness activities for students, parents, and providers through classes in schools, in community agencies, and through health fairs, media presentations, and loans of films and materials is a TAPPP priority. Data for CY 2007 showed that statewide staff provided family life education programs to almost 71,185 adolescents and 20,150 adults, and worked with 8,776 parents and 7,764 professionals.

The Department contracts with United Neighborhood Health Services, a Nashville-based health care group, to staff a toll-free information line specifically for teens. Four staff members who regularly provide prevention and intervention services staff the line from 8:30am to 5:00pm Monday through Friday.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide family planning services in all 95 counties.	X			
2. Provide education in community settings related to adolescent health and prevention of risk taking behaviors.				X
3. Continue TAPPP coordinators activities and coalitions.				X
4. Emphasize services for adolescents, including direct services, care coordination, and referral.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Abstinence Education Program has not been conducted since June 30, 2007. At that time, Congress withdrew 12-month funding cycles of Title V, Section 510 for states and began issuing 3- and 6- month cycles. This was deemed insufficient time to establish contracts and conduct meaningful abstinence education and youth development programming. Should congress extend funding to the original 12-month cycles, Tennessee will consider restarting its program. The annual Celebrating Healthy Choices for Youth Conference focusing on abstinence and youth development activities is now expanded to cover all MCH programming concerns.

The Community Prevention Initiative currently funds 36 programs in 23 counties, targeting children 8-16 who are at high risk for becoming involved in drug and alcohol abuse and adolescent pregnancy.

New members are being added to the Adolescent Health Advisory Committee. Members are selected based on their expertise in one or more areas of youth health care, well-being and development. The online Adolescent & Young Adult Health in Tennessee Report statistics are being updated in as new data becomes available. "Your Health Is In Your Hands", a comprehensive health guide for adolescents and young adults was distributed across the state to non-profit agencies upon request.

c. Plan for the Coming Year

MCH programs will continue to offer clinical and educational services to the adolescent population and offer support, technical assistance, and training to community agencies and other groups working towards lowering the teen pregnancy and birth rates.

The state's overall teen birth rate has been declining over the last decade, and projections indicate that this trend will continue. The availability of reproductive health services, health education, and community support for the prevention of teen pregnancy has all contributed to this improvement. Programs such as the Tennessee Adolescent Pregnancy Prevention Program, the Family Planning Program, and youth development and assets building training have provided leadership towards lowering the teen birth rate and achieving this objective.

Adolescent pregnancy (ages 10-17) data for 2006 show the lowest rate recorded since 1975--13.7/1000. The rate dropped for both the white and the black populations; however, the gap between the two groups remains. For 2006, the rate for the black adolescent population was 2.2 times that for the white population (ages 10 -- 17). However, pregnancies in the 15-17 age groups increased, from a rate of 33.8 in 2005 to 35.0 in 2006.

In 2006, there were 4,150 pregnancies to this age group, with 3,392 actual births (15 = 438; 16 = 1,048; 17 = 1,906). As in the larger adolescent group, this sub-group shows a substantial gap between the black and white populations. The baseline rate for births to adolescents ages 15-17 was 42.5/1,000 in 1995. By 1998, the rate had fallen to 38.1/1,000. The age-specific fertility rate for adolescents age 15-17 in calendar year 2006 was 28.3. This continues the decreasing rate for this population.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	17	17	25	23	23
Annual Indicator	9.3	22.0	21.9	22.3	21.8
Numerator	6476	35059	71961	75789	3769
Denominator	69314	159359	329279	339485	17256
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**

Annual Performance Objective	24	24.5	25	25	25

Notes - 2007
This data is from the of Tennessee (Patient Tracking Billing Medical Informatin System) PTBMIS Database.

Notes - 2006
This data is from the of Tennessee (Patient Tracking Billing Medical Informatin System) PTBMIS Database.

Notes - 2005
This data is from the of Tennessee (Patient Tracking Billing Medical Informatin System) PTBMIS Database.

a. Last Year's Accomplishments
The School Based Dental Prevention Program (SBDPP) is a statewide, comprehensive dental prevention program for children in grades K-8 in schools with 50% or more free and reduced lunch. It consists of three parts; a dental screening and referral, dental health education, and application of sealants. During FY 07 (July 1, 2006 - June 30, 2007), school based dental prevention services were being delivered in all 13 regions. Data for FY 07, shows that 139,310 children had dental screenings in 365 schools. Of these, 35,107 children were referred for unmet dental needs. Full dental exams were conducted on 69,530 children. A total number of 294,191 teeth were sealed on 52,580.00 children. 168,374 children received oral health education programs at their schools by a public health hygienist. Dental outreach activities include provision of informational material for TennCare enrollment purposes and follow-up contacts for all recipients identified as having an urgent unmet dental need.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide clinical dental services to TennCare children.	X			
2. Provide preventive dental services including sealants and oral health education to children in schools.	X	X	X	
3. Provide dental outreach activities.		X	X	
4. Provide dental services using the three mobile units in Northeast, mid-Cumberland and West Tennessee Regions.	X	X		
5. Continue the fluoride varnish program.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Cavity Free in Tennessee (CFIT) program is expanding throughout the state. Currently all the rural regions are providing these expanded dental preventive services. From July 1, 2006-June 30, 2007 approximately 10,500 at risk children have been screened, referred, and had fluoride varnish applied in Tennessee Department of Health medical clinics by nursing staff.

The School based dental prevention program will continue to provide comprehensive preventive dental services to underserved, at-risk children in the school setting.

The clinical dental program will continue also to expand access to services to include the prenatal population and improve existing facilities.

c. Plan for the Coming Year
Central office staff will continue to provide support and serve as a resource for the CFIT Public Health Nursing Fluoride Varnish program through an updated training manual and addition of new user friendly fluoride varnish to our statewide supply contract.

Central office staff will be conducting a statewide survey of elementary aged school children in 08-09.

Central office staff will continue to support both the mobile and fixed dental clinical facilities as well as provide guidance to the School Based Dental Prevention Program. Oral Health Services will continue to work toward its goal of entering the data from the school based dental prevention program exams (approximately 70,000 children) into a database for follow up on students participating in the school based prevention program in an effort to address the 2010 Healthy People Objectives.

Dental services are required under EPSDT guidelines. There are shortages of general dentists accepting TennCare in the rural areas and a shortage of specialists in both rural and metro areas. To counteract this shortage, the Rural Health Initiative allows health regions to submit proposals through their Regional Health Councils to establish special dental, obstetric, pediatric and/or primary care services needed in their communities. Three regions have chosen to develop mobile dental services targeting school children during the school year and providing services to other disparate populations during holidays and summer.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	3.7	3	3	3	2.5
Annual Indicator	4.0	4.2	4.0	2.6	3.3
Numerator	48	50	48	32	39
Denominator	1188005	1196148	1204737	1210629	1194718
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	2.5	2.5	2	2	2

Notes - 2007

The data reported in 2007 are pre-populated with the data from 2007 population estimates and the Tennessee Death Master file for this performance measure.

Notes - 2006
The data reported in 2007 are pre-populated with the data from 2007 population estimates and the Tennessee Death Master file for this performance measure.

Notes - 2005
Data source is the State of Tennessee Health Statistics System

a. Last Year's Accomplishments
Injury Related Deaths Among Children: The state's rate of death from motor vehicle crashes for children ages 14 and younger has been on the decline since 1994. In 2005, there were 242 deaths (22.63% of all childhood fatalities) due to injury among children. The greatest numbers of childhood fatalities were due to injuries resulting from vehicular incidents (111) or 45.87% of all injury-related fatalities.

Vehicular Deaths Among Children: In 2005, 111 children died in vehicle related incidents. This represents 45.87% of all injury related deaths and 22.63% of all child fatalities for 2005. In 2005, the death rate for infants less than one year, was 3.9 per 100, 000 population. Male children (8.73 per 100,000 population) were most likely to die from a vehicle related incidents than females (6.6 per 100,000 in the population). Whites had a slightly higher rate of death from vehicle related incidents than African Americans (9.28 versus 6.09 respectively).

Fatalities Due to Vehicular by Age, Sex and Race (N = 111)

Age	Number	Rate	Sex	Number	Rate	Race	Number	Rate*
<1	7	78.79	F	53	7.83	AA	18	6.09
1-2	7	4.52	M	58	8.43	White	92	9.28
3-5	5	2.20				Other	1	0.07
6-8	8	3.62				Asian	0 **	
9-11	7	7.09				Missing	4 **	
12-14	18	7.56						
15-17	59	24.32						
TOTAL	111	7.95		111	7.95		111	7.95

* Rates per 100,000 population
** Rates not available
Source: Tennessee Department of Health, Maternal and Child Health Section, Bureau of Health Services, Child Fatalities in Tennessee. 2005.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate health department staff and the general public about the child safety law.			X	
2. Provide child safety seat checks at local health departments and other community sites.	X			
3. Conduct injury control activities on seatbelts and child safety			X	

seat usage.				
4. Partner with local law enforcement agencies, Safe Kids Coalition, head Start Centers, school systems, and Governor's Highway Safety Office.				X
5. Provide education to students, train providers, participate in exhibits and health fairs, etc. as required.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2003, Governor Bredesen signed a law which revised the passenger restraint law. The new law went into effect July 1, 2004 and requires a child to be in a proper safety restraint system (i.e., car seat or booster seat) based upon age, weight and height when riding in a passenger vehicle. The revised law increased fines and broadened the age for protection as an impetus to increase the number of children who are properly restrained in passenger vehicles.

In 2007, over fifty (30) organizations participated in the Child Safety Fund program which was enacted through the Child Safety Act of 1989 by the Tennessee General Assembly. During this fiscal year, a total of $155,808.14 was disbursed to hospitals providing obstetrical services in Tennessee for the purchase of child restraints systems.

c. Plan for the Coming Year
The Department of Health, the Department of Transportation and Safety and our partners will continue efforts to reduce the number of deaths and preventable injuries among children and adults due to lack of proper restraints.

Also, the Injury Prevention and Control Program of the Department of Health will formulate an operational work plan in keeping with the programs' goals, which are:
To mobilize partnerships and engage individuals at multiple levels in activities which identify risk factors and promote a reduction in unintentional injuries derived from unhealthy safety practices.
To promote the development and implementation of initiatives and services promoting injury prevention and safety.
To provide technical support and training.
To work with communities and promote policy change.
To evaluate and improve programs.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				32	34
Annual Indicator			29.3	28.0	31.4
Numerator			440	420	14705
Denominator			1500	1500	46777
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	36	40	50	50	50

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2007 population estimates and the CDC Nutrition Surveilance file for this performance measure.

Notes - 2006
Data source is national Immunization survey. Source: CDC.gov/breastfeeding/data.
The numerator and denominator are based on estimates.

Notes - 2005
Data is from National Immunization Survey. Tennessee 29.1 (+ - 4.2) Percent of 95 % confidence interval. Source: CDC.gov/breastfeeding/data
The numerators and Denominator are based on estimates of the CDC survey.

a. Last Year's Accomplishments
Breastfeeding is widely promoted through the WIC program and local health departments must establish and maintain an environment which supports and encourages women in the initiation and continuation of breastfeeding. Print and audio-visual materials in the clinic must be free of formula product names and formula stored out of the view of clients. Educational materials are to portray breastfeeding in a way that is culturally and aesthetically appropriate for the population served. Health departments must have a designated area for moms who prefer to breastfeed in a private place. In addition, each of the thirteen established nutrition centers has a room exclusively for breastfeeding mothers to use.

Breastfeeding counseling is a required nutrition education component of the WIC Program and all pregnant women are encouraged to breastfeed, unless contraindicated for health reasons. Breastfeeding education is offered individually and in group settings. WIC serves over 21,000 pregnant women and enrolls approximately half of newborns in the state. Thirty percent of WIC delivered mothers are breastfeeding at time of postpartum certification. Presently, there are 7,646 breastfeeding mothers on the WIC program. WIC provides on-going breastfeeding information and counseling in the clinic, hospital, and home setting. Manual and electric pumps are issued to eligible mothers. Mothers who deliver prematurely or have a baby in the Neonatal Intensive Care Unit are given priority for hospital grade electric pumps.

Furthermore, HUGS (Help Us Grow Successfully) directors and home visitors attended regional workshops on breastfeeding in 2007. The 2-3 hour in-service covered the basic foundational principles every counselor must know to help mothers get off to a good start with breastfeeding and how to address problems early to help prevent mothers from weaning early. Combining breastfeeding education and support and HUGS home visits has potential to significantly increase breastfeeding rates.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Breastfeeding coordinators and advocates in every region work with health care providers, health department staff and postpartum women to assist and promote breastfeeding.	X	X		
2. Breastfeeding data are routinely collected on WIC clients.				X
3. The Baby Friendly Initiative continues in local health department clinics.	X	X		
4. An USDA grant using social marketing principals is being used to promote breastfeeding in West Tennessee.			X	
5. An USDA infrastructure grant continues to be used to do more intensive data collection and evaluation among WIC programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2005, Tennessee implemented the breastfeeding peer counselor program that is consistent with model components for building a successful program. Peer counselors are paraprofessionals, ideally a current or previous WIC client, with breastfeeding experience and a desire to help other mothers succeed with breastfeeding. By combining peer counseling with the on-going breastfeeding promotion efforts in the Tennessee WIC program, the peer support counselor program has the potential to significantly impact breastfeeding rates among WIC participants, and, most significantly, increase the harder to achieve breastfeeding duration rates. The long-range vision is to institutionalize peer counseling as a core service in WIC. Currently, there are 30 peer counselors in the state, including 16 funded by a USDA grant. Breastfeeding rates increased in 15 of 18 counties receiving grant funds to hire a peer counselor.

c. Plan for the Coming Year

Plans for the coming year include continuing the breastfeeding peer counselor program and continuing to work with HUGS to strengthen breastfeeding support for mothers and their families.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	97.0	97.0	97.0	88.9	92.5
Numerator	76476	77202	79010	80173	85077
Denominator	78841	79590	81454	90155	92012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	98	98	98	98	99

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2007 population estimates for this performance measure.
Secondly 2007 data is based on population estimates.

Notes - 2006
Data source is the State vital records and Newborn screening registry.
No law requires hospitals in the state to report on screening.

Notes - 2005
Data source is the State vital records and Newborn screening registry.
No law requires hospitals in the state to report on screening.

a. Last Year's Accomplishments
In 2006, without a legislative mandate, hearing screening results were reported on 90% of the estimated 89,120 resident and non-resident births (National benchmark 95%). Although not mandated, 100% of the 82 birthing facilities provided hearing screening and are required by State rules and regulations to report results on the blood spot form. 2006 data indicated that 3,499 (3.5%) infants did not pass the initial hospital screen (National benchmark less than 4%). 1,933 (0.2%) of all infants screened were reported to have at least one risk factor for hearing loss. There is no mandate to require reporting of hearing follow-up, however, follow-up was received on 77% of the infants (including those reported as lost to follow-up); 65% received further hearing testing. (National benchmark 90%). 71 infants were diagnosed with hearing loss (50 had permanent loss); 49 had bilateral loss and 22 had unilateral loss. The expected incidence of hearing loss for Tennessee is 89-127 infants (National incidence 1:1000 to 3:1000).

The number of follow-up hearing tests reported by individual providers and audiologists continued to improve. In 2006, 1,025 reports were submitted by audiologists/otolaryngologists; 385 were submitted by medical home providers; 154 by hospitals; 147 by parents; 1,556 by early intervention TEIS/TIPS. These data include reports by several providers for one infant. Hospitals are required to indicate a medical home provider on the blood spot form. Long term NICU babies list the NICU MD as the provider. Parents are asked by Hospital staff to select a provider, if there is no provider the local health department is listed as the provider. The medical home providers are notified on all infants that require follow-up and are provided a form to report follow-up results. When a physician indicates that the infant is not a client, TEIS is notified to provide follow-up. After receiving a follow-up letter, parents frequently report that they were advised by the hospital that the infant passed the screen. It has been determined that the hospital reported the initial "refer" on the blood spot form and then conducted additional testing prior to discharge, however the final "pass" result was not reported to the state program. The challenge is to increase awareness of the need for reporting of "final" hearing results prior to discharge and to assure access to reporting forms and provide other avenues to report results.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote newborn hearing screening in all birth facilities.			X	
2. Promote the use of the data collection system by all birthing facilities.			X	
3. Provide technical assistance and education to providers.				X
4. Revise, as needed, the directory of hearing providers.				X
5. Coordinate referrals and follow-up on infants with abnormal results.			X	

6. Coordinate the activities of the Newborn Hearing Screening Task Force.				X
7. Distribute educational materials for parents, providers, facilities, and intervention programs.			X	X
8. Utilize survey and assessment materials to monitor effectiveness of program components.				X
9. Conduct site visits to hospitals to monitor screening effectiveness, access to evaluation, and parent/provider satisfaction.				X
10.				

b. Current Activities

Preliminary 2007 data indicated 92.5% of infants received a hearing screen; an estimated 50 were identified with hearing loss. Legislation to mandate hearing passed April '08 and is effective in July. Rules will be developed to implement the mandate and include hospital tracking for screening or appointment for screening. Hospital guidelines are being revised. The guidelines for hearing follow-up provided by the TN Early Intervention System were revised to reflect TEIS program changes; training will be held. Quarterly meetings with the Newborn Hearing Task Force and subcommittees continue. Twelve representatives attended the 2008 EHDI Conference, including 4 parents, 3 audiologists, 2 Part C early interventionists, 1 hospital hearing screening staff, 1 program director and 1 MD-APP Chapter Champion. An audiology consultant (0.5 FTE) provides training and consultation to hospitals, audiologists and medical providers and works directly with TEIS to develop policies and conduct training. Three part-time family support parent consultants conduct outreach to groups and individual families. A web site and Hearing list-serve are now available through Family Voices. NHS data, forms and information are now on the state web site. Steps were implemented to link 2007 newborn metabolic and hearing screening to birth certificate data. Preliminary data from the linking identified those infants (1% of the population) that did not receive a blood spot screen or hearing screen.

c. Plan for the Coming Year

The program plans to increase the number of infants screened from 92.5% to 95% by April 2009 and to reduce the number of infants that do not receive follow-up testing from 35% to 25%. Implementing hearing legislation will promote better reporting of screening and follow-up. The newborn screening data system will be expanded by June 2008 to include specific diagnostic and long term follow-up on the Neometrics data system. This will eliminate the need for two data systems for hearing tracking and will provide timely and accurate information to assess and monitor program goals and effectiveness.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	7	7	7	6	6
Annual Indicator	7.5	10.8	6.4	6.4	6.4
Numerator	119428	173220	97933	97933	88283
Denominator	1592371	1603892	1530196	1530196	1386911
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5					

and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	6	6	6	6	6

Notes - 2007
Data source is National survey of Children's health.
93.6 % of children had health insurance according to the survey (WWW.nschdata.org)

Notes - 2006
Data source is National survey of Children's health.
93.6 % of children had health insurance according to the survey (WWW.nschdata.org)

Notes - 2005
Estimate was generated from the National survey of children health where 93.6 % of children had health insurance.
It is anticipated that the State of Tennessee might have Coverkids health coverage and this will cover both kids and pregnant women.

a. Last Year's Accomplishments
Data on the percent of children in Tennessee without health insurance can be found in several national sources, but for varying age groups and income levels. U.S. Census Bureau, 2004 Annual Social and Economic Supplement, Current Population Survey data show that 86.8% of all persons and 89.2% of children under age 18 were covered by some type of health insurance. U.S. Census data for a three-year average for 2001-2003 show that 5.6% of the 61,500 children under age 19 and at or below 200% of poverty were without health insurance in the state. Data from the Children's Defense Fund show that 7.5% of children under age 19 were without health insurance in 2002, with a three-year average for 2000-2002 of 7.0%.

The state's managed care program for Medicaid recipients and uninsured remains the major focus on providing health insurance coverage for children. In FY 2006, 814,643 children ages 0-21 years were enrolled in TennCare statewide. Of these, 6.9% percent were under one year of age and 18.5% were ages 6-9.

The Department has negotiated agreements with all of the MCOs operating in the rural regions to provide some traditional public health services without prior authorization. The Bureau also had agreements with selected MCOs to provide gate keeping primary care services in eleven rural counties. Since July 2001, TennCare has requested that the local health departments assist with providing Early Periodic Screening, Diagnosis and Treatment (EPSDT) screenings to TennCare enrollees. During state FY 2006-07, health department clinics provided 58,276 EPSDT screenings.

All local health departments offer pregnancy testing. If the patient is pregnant, the health department screens for income and determines if the woman qualifies for prenatal presumptive eligibility, a TennCare Medicaid category of coverage for pregnant women. Four criteria must be met for the woman to qualify for presumptive eligibility: Tennessee residence, valid social security number, household income at or below 185% federal poverty level and verification of pregnancy. The information is entered into the TennCare data base directly by health department staff so that the women are immediately on TennCare and eligible for coverage of needed services for at least 45 days. TennCare coverage will end after the 45 days unless a TennCare application is made with the Department of Human Services and the woman is approved for continued coverage in TennCare.

All children enrolled in the Children's Special Services program are required to apply for enrollment in TennCare. Ninety percent of children in the program receiving medical services are

on TennCare. Each child is assigned to a program care coordinator who assists the family in accessing needed medical services, including preventive, routine medical care, and specialty care. The care coordinator also assists the family with the TennCare appeals process, as needed.

All local health department clinics provide advocacy and outreach for TennCare, and through contact with low income persons and families receiving a wide variety of services (home visiting, family planning, immunizations, etc.) make referrals to the Department of Human Services (DHS) for potential enrollment into TennCare.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and advocacy services in all health department clinics for TennCare enrollees.		X		
2. Provide EPSDT screenings for TennCare enrollees.	X			
3. Provide EPSDT screenings for children in state custody.	X			
4. Continue the EPSDT community outreach project.		X		
5. Provide presumptive eligibility for pregnant women in all health department clinics.		X		
6. Assist all children applying for CSS services with enrollment in TennCare.		X		
7. Assist TennCare enrollees with the TennCare appeals process.		X		
8.				
9.				
10.				

b. Current Activities

For FY 2006, TennCare data show that there are 814,643 children ages 0-21 years on TennCare. Of these, 56,537 are less than age one, and 150,683 are ages 6-9. All local health department activities described in the report of last year's accomplishments continue. Referrals are made to the Department of Human Services (DHS) for TennCare enrollment of any families with children who may qualify. All local health department clinics provide presumptive eligibility for pregnant women to enroll in TennCare and referral to DHS for enrollment; this service not only assists with entry into prenatal care, it provides for enrollment of the infant at birth. All health department clinics provide EPSDT screening exams for children.

Currently, eleven of the rural counties are gatekeeper counties and have been assigned 15,000 TennCare clients by the managed care organizations. These enrollees include persons of all ages. The Department continued its TENNderCare outreach initiative to encourage parents of children and youth to take advantage of free health screenings for their children.

c. Plan for the Coming Year

Departmental activities related to children and insurance coverage described previously will continue: enrollment of pregnant women in TennCare under presumptive eligibility; enrollment of CSS children in TennCare and assistance with access to care by the care coordinators; provision of EPSDT screenings for TennCare children; outreach and advocacy activities for TennCare enrollees; EPSDT community outreach initiative; EPSDT Call Center; provision of primary care services in selected counties; and referral of children/families to DHS for TennCare enrollment.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				9	9
Annual Indicator			10.3	24.2	34.0
Numerator			20474	22265	53971
Denominator			197847	92164	158733
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	30	30	30	30	27

Notes - 2007
Data source is the State WIC data base and is the calendar year data
Variation is due to calendar year data, increase in the total number of children within the age group of 2-5 years receiving WIC and methodology of data count.

Notes - 2006
Data source is the State WIC data base and is the calendar year data
Variation is due to calendar year data and methodology of data count.

Notes - 2005
Data source is state WIC database. Data categories may include children under the age of 2 years to 5 years.

a. Last Year's Accomplishments
Utilizing the state PTBMIS computer system, specific surveillance data is obtained and examined using the Centers for Disease Control (CDC), Pediatric Nutrition Surveillance System [Ped NSS (pre2004 version)] to calculate provisional analysis, final results are prepared by CDC. Preliminary information was supplied to 14 regional nutrition directors for development of FY 06-07 nutrition plans. Two different reports have either been initiated or are available at the regional level. The High/Low listing is supplied on a by monthly basis which shows only participants whose certification values are outside the range for age and sex. These listings also provide the BMI for all participants that appear in this report. A second set of reports has been developed listing individuals with assessment values judged to potentially impact the development and wellness of the participants. In FY 05-06 each region developed an activity addressing overweight in an objective in their current state plan.

In aide of accuracy to detect changes in the percentage of overweight and/or risk of overweight almost all of the clinics providing WIC services are equipped with electronic digital scales. Calibration procedures are in place to promote correct weight determinations in the clinics. Techniques used to assure accurate weight, and hematology are periodically revisited in the regions and/or offered in individual clinics. In addition to providing of tracking BMI, the incidence of anemia can be followed if markedly unusual change in the incidence of anemia is reported. The anemia data is divided on the basis of age: children <24 months of age and those 24-60

months. This division was instituted to identify progress toward the goal of Healthy People 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide data and provisional analysis to regional and local nutrition directors for program development.				X
2. Assist with training when policy changes are instituted.				X
3. Provide computer program to track birthweight of WIC participants.				X
4. Provide up to date information of overweight and anemia to local health department programs.				X
5. Monitor compliance with policy and completeness of data at regional and local WIC programs.				X
6. Provide refresher sessions on as needed basis to regional nutrition, nursing and clerical directors.				X
7. Continue to utilize the state PTBMIS computer system for surveillance.			X	X
8. Continue to examine (CDC) pediatric Nutrition surveillance system to calculate provisional analysis for program planning and development purposes.			X	X
9.				
10.				

b. Current Activities

All regions are kept up to date on the incidence of overweight and anemia in the pediatric WIC participants. The reports currently available afford indicators of correctness, compliance with policy, and completeness of data input on both initial and recertification of participants.

Discovery of marked changes in percentages of participants classified as overweight and/or anemic is followed up with regional staff. If discussions with regional nutrition, nursing and clerical directors lead to requests for refresher session they are presented to the specific disciplines involved with certification of the WIC program participants.

c. Plan for the Coming Year

The reports will continue to be provided and upgraded. Techniques used in assessments and data input will be followed. The incidence of anemia as well as BMI at the 85th percentile will be followed. Methods to specifically illustrate with high percentages of variables will be sought. Special attention to detect and reasons for identified condition will be followed up. Assistance with training, when policy changes are instituted will be provided. Such sessions will also focus on highlighting excellence of work as well as areas where obvious care with details is considered necessary, or if requested by a region.

A new computer program will be offered to track low birth weight WIC participants.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				9.7	9
Annual Indicator			16.2	15.8	19.4
Numerator			13158	13288	16774
Denominator			81454	84277	86558
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	7.5	6	4	4	4

Notes - 2007
Data source is the State vital records

Notes - 2006
Data source is the State vital records

Notes - 2005
Data source is the State of Tennessee Health Statistics System

a. Last Year's Accomplishments
The state's large WIC program targets pregnant women as the highest priority. Data for May 2006 show a caseload of 21,324 pregnant women (13.6% of the caseload). Local health department clinics performed 71,389 pregnancy tests during CY 2005, and enrolled 12,642 pregnant women in TennCare for presumptive eligibility during the same time period. All these visits, as well as the home visiting program for pregnant women, provide opportunities to educate and counsel on smoking cessation and to make appropriate referrals. The prenatal care guidelines and protocols for nurses and the home visiting protocols provided guidance to staff on these topics.

In September 2007, the Department of Health initiated a smoking cessation program which targeted pregnant women and teens: It included: 1) evaluating all health department clients, 13 years or older, with a survey, and implementing the evidenced- based 5As or 5Rs approach; and 2) if client expressed the desire to stop tobacco use, he/she was offered smoking cessation counseling through the Tennessee QuitLine, and/or pharmacologic treatment. This effort has met with fairly rapid success, significantly increasing the number of QuitLine users and persons agreeing to take smoking cessation medications. For pregnant smokers, the pharmocologic agents were not offered.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Support the activities of the TennCare/EPSDT Call Center staff related to calls to pregnant women and new mothers		X		
2. Provide pregnancy testing, counseling, referrals, and presumptive eligibility for TennCare enrollment in all health	X	X		

department clinics.				
3. Provide WIC/Nutrition services in all local health department clinics (all counties).	X	X		
4. Provide home visit services for pregnant women.	X			
5. Offer comprehensive prenatal care services, including counseling and education, in 10 counties.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Services described above continue. All health department clinics offer pregnancy testing.

The Governor's Office of Child Care Coordination awarded $1.44 million grant to a program at East Tennessee State University (ETSU) aimed at helping expectant mothers quit smoking. The Tennessee Intervention for Pregnancy Smoking project is also working to improve birth outcomes in Northeast Tennessee by improving the health status of pregnant women.

c. Plan for the Coming Year
The Department will continue to provide the services described above (pregnancy testing, counseling, referrals, WIC and nutrition services, home visiting services, prenatal care in selected counties, enrollment in TennCare under presumptive eligibility, TennCare outreach and advocacy, and its tobacco cessation program.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	7	6.5	6	6	6
Annual Indicator	6.2	10.3	7.5	7.2	5.4
Numerator	25	42	31	30	23
Denominator	404366	407744	411299	414947	422058
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5.2	5.2	5	5	5

Notes - 2007
Data source is the State vital records registry.

Notes - 2006

Data source is the State vital records registry.

Notes - 2005
Data was from State Vital records registry

a. Last Year's Accomplishments
The director of adolescent health continues as an active member of the Tennessee Suicide Prevention Network (TSPN). She also attends the bi-monthly intra-departmental meetings to address suicide prevention issues. The contact information for TSPN's web site was added to the adolescent health website page. The adolescent health guides contain information about suicide warning signs and provide national and state contact numbers. Suicide prevention training was provided in several health department regions this past year. The SAMSHA youth suicide prevention grant in partnership with the Tennessee Department of Mental Health and Developmental Disabilities was received and implemented. The awarded grant proposal called for all the Department's public health nurses working in local health departments to receive youth suicide prevention gatekeeper training.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute youth health guides statewide to providers and youth (Suicide information is included).			X	
2. Continue to partner with the suicide Prevention Network (SPN).				X
3. Participate on the SPN subcommittee on youth suicide prevention plan.				X
4. Continue to assist with carrying out the State Youth Suicide Prevention Plan.			X	X
5. Continue to distribute fact sheets on adolescent suicide prevention.				X
6. Provide statewide training on youth suicide prevention.				X
7.				
8.				
9.				
10.				

b. Current Activities
The director of adolescent health continued her involvement with the Tennessee Suicide Prevention Network and developed updated fact sheets for youth suicide prevention that will be available via the department's website. The completion of the SAMSHA youth suicide prevention grant proposal is an immediate task.

The training of the nurses continued throughout the year.

c. Plan for the Coming Year
The director of adolescent health will continue to partner with the Tennessee Department of Mental Health and Developmental Disabilities and the Tennessee Suicide Prevention Network to implement the SAMSHA grant.

The director of adolescent health will provide QPR training to state health department staff as well as remain active in the activities of TSPN. The adolescent health youth guides will continue to be distributed throughout the state. These guides include information about the warning signs of suicide as well as contact numbers for those needing assistance. The guides will be printed in

Spanish this year and distributed to Spanish-speaking youth throughout the state. Youth suicide prevention fact sheets will be developed and marketed to youth serving groups. Regional suicide prevention resource directories will be distributed to all local health departments in Tennessee.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	80	80	80	80	80
Annual Indicator	74.8	72.3	68.0	69.3	68.5
Numerator	1004	815	922	1045	1036
Denominator	1343	1128	1356	1508	1513
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	80	80	80	80	80

Notes - 2007
Data source is the State vital records registry.

Notes - 2006
Data source is the State vital records.

Notes - 2005
Data source is the State of Tennessee Health Statistics System.

a. Last Year's Accomplishments
Data for the determination of the percentage of very low birth weight infants born in tertiary level facilities are compiled by Health Statistics. Information on facilities by level of care is collected on the Joint Annual Report of Hospitals and is only used for statistical analysis. Data from 2004-2006 show a range of 70.7% to 74.9% of VLBW babies delivered in tertiary level hospitals. Provisional data for 2007 for total very low weight births, as compared to 2006, show an increase of 3 infants, but a decrease of one percent.

The state has five regional perinatal centers providing specialty care for high risk pregnant women and infants, as well as consultation to all health care providers within the respective geographic area. This system has been in place in the state since the 1970s and is well established and recognized. Medical staff in all five centers are available for 24 hour consultation for both high risk obstetrical and neonatal care. Education and training for providers within the geographic areas is provided by all the centers. An advisory committee, established by legislation and coordinated by Women's Health staff, advises the Department on issues and concerns related to perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, guidelines for perinatal transportation, and educational objectives for nurses and social workers working in perinatal care. Contracts between TennCare and the managed care organizations require that the MCOs work with the perinatal center(s) operating in their geographic area.

The continually changing health care environment plays a role in the low rates of VLBW infants being born in tertiary level hospitals. Also contributing is the difficulty in capturing data on the level of care by facility. The system for determining level of care in the state is self-designation, not regulatory.

All services within the regional perinatal centers continued during the past year. Women's Health staff worked with the Perinatal Advisory Committee to review, revise, print, and distribute the transportation guidelines. The document was placed on the Department's web site for easy access by health care providers, emergency responders, and facilities.

During state FY 2007, the five obstetrical perinatal centers had 14,505 deliveries for Tennessee residents (out of 86,558 provisional resident births for CY 2007), documented 1,844 telephone consultations and 17,187 onsite patient consultations, and taught 1,909 hours of education. Data from the five neonatal perinatal centers for the same time period show 2,892 in-born admissions to Tennessee residents, of which 570 were VLBW (2007 provisional VLBW births were 1,513); 1,610 transports; 2,214 on-site consultations; and 3,267 hours of education taught.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue the perinatal regionalization system.	X			X
2. Coordinate the activities of the Perinatal Advisory Committee.				X
3. Update and revise perinatal program manuals as needed.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The structure of the five regional perinatal centers continues to be in place. The state (TennCare) contracts with each of the centers to support the infrastructure of the centers (consultation, professional education, maternal-fetal and neonatal transport, post-neonatal follow-up, data collection, and site visits to hospitals upon request). Staff at all centers are available to health care providers in the appropriate geographic area to provide consultation, assistance and referral for any high risk pregnant woman or infant. The revision to the regionalization guidelines ("Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities") will begin this summer with a work group of experts in the field from across the state. In November 2007 the Perinatal Advisory Committee and the Department of Health sponsored a Community Forum to explore a statewide quality collaborative to improve birth outcomes in the state. Attendees, including perinatologists, neonatologists, hospital administrators, third party payors, state officials, and community constituents, heard information from collaborative initiatives in California, North Carolina, Ohio, and Vermont; proposed implementation strategies for Tennessee; and began work on an action plan. Despite a tremendous amount of effort, the proposed plan was not funded by the state.

c. Plan for the Coming Year

The state will continue to contract with the five regional perinatal centers as in the past. The Perinatal Advisory Committee will continue to advise the Department on perinatal care issues and revise manuals as needed. Work on the revision to the regionalization guidelines will be completed during the coming year as needed. A new work group will be formed to review and revise the "Educational Objectives for Nurses, Levels I, II, III, Neonatal Transport Nurses" manual.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	89	90	90	90	90
Annual Indicator	80.6	80.4	60.4	62.5	63.7
Numerator	63551	64000	49163	52684	55134
Denominator	78841	79590	81454	84277	86558
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	90

Notes - 2007
Data source is the State vital records registry.The data is estimated.

Notes - 2006
Data source is the State vital records registry.

Notes - 2005
State Vital Records
Data source is the State of Tennessee Health Statistics System

a. Last Year's Accomplishments
2006 birth certificate data show that 62.5% of pregnant women started prenatal care in the first trimester; however, these data continue to reflect problems in using the new birth certificate format and an incompleteness of the data. Prior to implementation of the new format, over 80% of women were starting prenatal care in the first trimester. There is no other known reason for the drop in the percentage except for the new format. Data from the TennCare/Medicaid HEDIS report show that for 2006 75.6% of their enrollees entered prenatal care in the first trimester, and 77.9% for 2007. Almost half of the births in Tennessee are on TennCare/Medicaid.

The Department of Health has historically considered the reduction of infant mortality and improving birth outcomes as priorities. The role of the Department is to remain abreast of evidence-based best practices and to implement public health initiatives and programming consistent with those practices. All local health department clinics offer basic prenatal care, which includes pregnancy testing (80,003 in CY 2007), presumptive eligibility determination for TennCare (15,189 enrolled in CY 2007), WIC/nutrition services, counseling, information, and

referrals to health care providers for medical care. The availability of these services in all counties increases the likelihood that pregnant women will enter into care early. Women are also referred for home visiting services as appropriate (HUGS, Healthy Start, or CHAD).

Under the managed care system in place under TennCare, most prenatal care is provided by private sector providers. Local health department clinics provided comprehensive prenatal care in 10 counties. Delivery services are by a private physician in the community. Many of these counties are serving primarily Hispanic clients; most do not have insurance or do not qualify for TennCare.

During CY 2007, 3,179 pregnant women were provided comprehensive care, and of these, 83% were self pay (not on TennCare) and 61% were Hispanic.

During FY 2007, the Department received a CDC PRAMS grant; implementation began in May.

Using new funding from the State, the Governor's Office of Children's Care Coordination has worked to develop an initiative to improve birth outcomes in Tennessee. After first assessing need related to obstetrical care and infant mortality and partnering with numerous agencies and providers, programs and projects, using evidence-based models, have been implemented in Memphis, Chattanooga, Nashville, and Northeast Tennessee. Funded activities include an awareness conference, training on the Centering Pregnancy model, equipment for providing obstetrical care, smoking prevention strategies, and leadership and clinical staff.

The Campaign for Healthier Babies operating in Memphis and West Tennessee since 1993 is a media and educational effort to improve rates of first trimester prenatal care entry and birth outcomes. The Campaign centers around a toll-free number promoted through television, newspaper, and print materials. Callers receive a free Happy Birthday Baby Book of information and merchandise coupons to be validated at prenatal visits. Women in the rural counties are provided the coupon book through health department clinics. In CY 2007, 8,036 phone calls were received at the Shelby County Health Department and 7,117 coupon books, along with folic acid, WIC, and other prenatal/infant educational information (16,312 brochures), were mailed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide pregnancy testing, counseling, and referral, and presumptive eligibility in all local health department clinics.	X	X		
2. Provide home visiting services for pregnant women.	X	X		
3. Provide comprehensive care in 11 counties.	X			
4. Provide WIC/nutrition services in all local health department clinics.	X	X		
5. Work with the Campaign for Healthier Babies in West Tennessee.			X	X
6. Continue operating the toll free Baby Line and the Live To 1 line.	X	X		
7. Coordinate with the Governor’s Office of Children’s Care Coordination on the efforts to expand availability of the obstetrical services in targeted areas and on establishment of FIMR teams.	X			X
8.				
9.				
10.				

b. Current Activities
All previously described activities continue. Emphasis is placed on providing pregnancy testing, assisting with prenatal care or arranging referrals to community private health care providers and offering home visiting services. 11 health departments offer full prenatal care. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a physician and are enrolled in WIC or CSFP. May 2008 WIC data show that 21,900 pregnant women were participating in WIC in 145 clinics.

The Governor's Office of Children's Care Coordination continued leading the effort to improve birth outcomes by funding programs and projects in areas of high numbers of infant deaths, including Community Voice in Memphis (grassroots, community education program), purchasing obstetrical equipment, training, staff for clinical care, smoking cessation case management, and health education.

The central office continues to operate the toll free Baby Line. Staff in the Department's EPSDT/TennCare call center contact all TennCare pregnant women and mothers of infants (birth to one year of age) and also answer the Live To 1 line which is advertised to the general public. These contacts are opportunities to discuss any concerns and problems of these pregnant women and new mothers along with providing education and information on prenatal, postpartum, and infant care.

First year PRAMS data will be complete this fiscal year; analyzed data will be available by December.

c. Plan for the Coming Year
All previously discussed activities will continue into the coming year. Local and regional health departments will continue to assess the need for providing prenatal care within their clinics depending upon the availability of services within the private health care systems.

The budget appropriation for improving birth outcomes also contained funding for the state to establish fetal-infant mortality review teams across the state. This effort will be coordinated by Maternal and Child Health staff and will begin with pilot programs in Nashville-Davidson County and the East Tennessee Region. These reviews should provide the state with additional and important data for planning strategies and interventions to improve early entry into prenatal care and birth outcomes. A new infant mortality awareness media campaign will be released in the coming year with messages for television, radio, and billboards. These messages were developed by teams of adolescents from the three largest metro counties as the primary product of a learning project for these youth.

D. State Performance Measures

State Performance Measure 1: *Reduce the percentage of high school students using tobacco (cigarettes and smokeless tobacco).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective		30		28	28
Annual Indicator	27.6	27.6	25.0	25.0	27.4
Numerator	515	515	385	385	422
Denominator	1865	1865	1540	1540	1540

Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	26	26	26	26	26

Notes - 2007
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used to estimate year 2007

Notes - 2006
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used to estimate year 2006

Notes - 2005
The 2005 Youth Risk Behavior Survey (YRBSS) was the sources.

a. Last Year's Accomplishments
Public Chapter 410, known as the "Non-Smoker Protection Act", was passed by the Tennessee General Assembly and signed into law by Governor Bredesen on June 11th, and will became effective on October 1, 2007. Under this new law, smoking is prohibited in all enclosed public places within the State of Tennessee with a few exceptions. The smoking ban applies , but is not limited to: Restaurants, public and private educational facilities, health care facilities, hotels and motels, retail stores and shopping malls, sports arenas, including enclosed public areas in outdoor arenas, restrooms, lobbies, reception areas, hallways and other common-use areas, lobbies, hallways and other common areas in apartment buildings and other multiple-unit residential facilities, and child care and adult day care facilities.

Tennessee General Assembly took a historic step and passed legislation to increase the state cigarette tax by 42 cents to 62 cents per pack. The new law went into effect July 1, 2007.

With the support of the Commissioner of Health and assistance from CDC, the Tobacco Use Prevention and Control Program prepared a budget improvement request for a Comprehensive State Tobacco Cessation Initiative to be implemented in FY 07-08. The Commissioner presented the request to the Governor during the department's budget hearing. The initial request totaled $3,540,000 but was revised up to $15,000,000. The final 1 year allocation to the Department is $10,000,000; $500,000 is to be used to sustain and enhance quitline systems and services and promotion, $1 million for youth initiation prevention, $1 million for community tobacco prevention programs and $6 million for NRT distribution thru local health departments.

The TUPCP launched a QuitLine web page which is accessible from the Tennessee Department of Health's website, http://health.state.tn.us/tobaccoquitline.htm and allows our regional staff, community projects, internal and external partners to freely print information on the services provided by the QuitLine, access promotional print materials and best practice strategies for offering services and treating tobacco use and dependency.

TUPCP/TDH secured earned media promoting the QuitLine from more than 25 sources including television news stations, public radio, radio stations, talk radio shows medical center journals, health system web reports, press releases, national, state and local news papers and health professional publications.

Under the direction of the new Assistant Commissioner of Health Services, the Department of Health convened an inter-departmental workgroup to integrate the U.S. Public Health Service guidelines for tobacco cessation and the Tennessee Tobacco QuitLine into cross cutting departmental programs. Workgroup members represent medical, pharmacy, dental, nursing, maternal and child health, women's health/family planning, nutrition, chronic disease/health promotion.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, manage and analyze screening data.	X		X	
2. Community Prevention Initiative will continue to fund 70 community-based programs in 51 counties that target high risk behaviors in youth.				X
3. Screen in local health department clinics, including screening EPSDT.	X			
4. Continue education of providers and citizens.				X
5. Develop a protocol for pregnant women.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the past year, the Tobacco Use Prevention and Control Program (TUPCP) continued to receive great support from CDC, North American Quitline Consortium, Tobacco Free Tennessee, national, state and local advocacy partners, internal and external partners, the Governor, Commissioner of Health and Assistant Commissioner of the Bureau of Health Services Administration.

Collaboration and partnerships on policy efforts are continued to be formed and strenghtened with the state advocacy coalition- Campaign for a Healthy and Responsible Tennessee (CHART); primary partners- American Cancer Society, American Lung Association, American Heart Association, March of Dimes; and local coalitions- Smoke Free Nashville, Tobacco Free Memphis, Kingsport Tomorrow, and the Anti-Drug Coalition of Jackson County.

The TUPCP maintains an email list by which announcements are made, information shared and action alerts are forwarded to regional program, community funded projects and strategic partners.

c. Plan for the Coming Year

The Tobacco Program will collaborate with CHART (Campaign for a Healthy and Responsible Tennessee), a grassroots coalition, to educate the public and motivate Tennesseans to advocate for moving policy change at the state level. The Tobacco Program through its youth empowerment focus will partner with CHART and other agencies to hold Youth Tobacco Summits in West, Middle and East Tennessee. The Youth Tobacco Summits will impart skills to empower youth to present tobacco prevention issues to their local legislatures and to civic groups and present their communities views on tobacco policy issues.

The Department of Health's program will continue to raise awareness of the dangers of tobacco use; mobilize the general public and priority populations; build capacity of state and local coalitions to effect tobacco related social norms, promote environmental change and support grass roots advocacy for non-tobacco policy. In addition, the state program will continue to support the Department of Health's Tobacco Cessation and Youth Prevention Initiative. The strategies being utilized are the promotion of tobacco cessation and SHS elimination.

The TUPCP plans to engage in strategic planning efforts to create a new 5 year plan for tobacco use prevention in Tennessee. In addition, the program plans to streghten its relationships with internal and external partners by convening quarterly meetings of the multiple strategic planning workgroups and maintaining monthly technical assistance and training teleconferences with regional staff and community program staff.

State Performance Measure 2: *Reduce the percentage of high school students using alcohol.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective		38		36	36
Annual Indicator	41.1	41.1	41.8	41.8	41.8
Numerator	772	772	643	643	644
Denominator	1878	1878	1540	1540	1540
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	34	34	34	34	34

Notes - 2007
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used to estimate year 2007

Notes - 2006
Data source is the Tennessee YRBS conducted by Tennessee Department of Education 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used to estimate year 2006

Notes - 2005
YRBSS was the data source.2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used

a. Last Year's Accomplishments
According to results from the 2007 Tennessee Youth Risk Behavior Survey (YRBS), 21.7% of all high school students admitted to binge drinking. About 69.9 percent of high school youth surveyed in the 2007 Tennessee Youth Risk Behavior Survey reported alcohol use at least once in their lifetime. Little difference was reported between the drinking habits of male and female high school students. More white students have had a drink and have been binge drinking compared to their African American counterparts.
• •22.3% of high school students reported that they had their first drink of alcohol other than a few sips by age 13 or younger.
• •5.2% of high school students report they have had at least one drink on school property.

The Bureau of Alcohol and Drug Services was transferred from the Department of Health to the Department of Mental Health and Development Disabilities inthe Spring of 2007. The state's preventive alcohol and substance use programs that target youth were transferred as well.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community Prevention Initiative will continue to fund 70 community-based programs in 51 counties that target high risk behavior in youth.		X		X
2. Provide home visiting services to pregnant women and		X		

families of infant and young children.				
3.				
4.				
5.				
6.				
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10.				

b. Current Activities

The Division's prevention services are primarily targeted to youth up to age eighteen and are provided at no cost to participants. They include:

1) Intensive Focus Prevention Programs are structured, intensive 8-12 session programs targeting youth up to age 18 who may be at risk for developing alcohol, tobacco, or other drug use problems. Programs are age-specific, developmentally appropriate, and culturally sensitive, and include a parent/care giver component;
2)Tennessee Statewide Clearinghouse for Alcohol and Drug Information and Referral provides an array of services including serving as a repository and distribution center for alcohol and drug information, serving as library for information related to substance use and abuse, serving as an information and referral center via a toll-free telephone service, and providing an Internet web-site of current substance use and abuse information for the public and professionals;
3)The Tennessee Teen Institute is designed to provide teen participants with the skills and education/information necessary to develop and implement alcohol and drug prevention programs in their own communities; and
4) The Faith Initiative seeks to prevent substance use problems by promoting local church involvement in outreach, training, and education services which target pre-adolescent children living in single parent households in inner-city housing developments.

c. Plan for the Coming Year

The Division of Alcohol and Drug Abuse Services will continue with the same activities to address adolescent alcohol usage. The Community Prevention Initiative will continue the same type and level of programming.
The Division's prevention services are primarily targeted to youth up to age eighteen and are provided at no cost to participants.

State Performance Measure 3: *Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	7.4	7.2	7	7	7
Annual Indicator	7.1	10.5	11.4	10.7	10.7
Numerator	10106	15143	17500	17500	17500
Denominator	1427042	1437424	1530196	1635539	1635539
Is the Data Provisional or Final?				Final	Provisional

	2008	2009	2010	2011	2012
Annual Performance Objective	7	7	7	7	7

Notes - 2007
Reports from the Tennessee Department of Children's Services Child Protective Services Section.

Notes - 2006
Reports from the Tennessee Department of Children's Services Child Protective Services Section.

Notes - 2005
The DCS numbers are based on the date that the investigation is completed and classified. The numbers do not necessarily reflect the year that the abuse and/or neglect took place. Therefore, the dramatic increase in the 2004 numbers is due mainly to the department's concerted effort to eliminate investigation backlogs. The backlog has reduced substantially and is expected to be caught up by the end of 2005. DCS reports that counting by the classification date allows for a more consistent accounting. If they reported by the incident date, then the numbers for all the years would continue to change and would be fluid. This accounting system allows for consistency. Once the case backlogs are caught up, it is expected that the victim count will stabilize and provide a more accurate assessment of trends from year to year.

a. Last Year's Accomplishments
Programs and health system activities that support this performance measure are: the mandatory reporting system; investigation by the Department of Children's Services and prosecution; community based programs for prevention education; the Child Fatality Review System; and the county home visiting programs in local health departments and contract agencies.

2006 data regarding child abuse and neglect rates continues to be the most current information reported by the Tennessee Department of Children's Services (DCS). In 2006, 11.7 children per 1,000 were abused and/or neglected. While responsibility for preventing and intervening in child abuse cases resides in DCS, MCH offers a variety of intervention programs at the county level to prevent and intervene before abuse occurs. The Child Health and Development Program (CHAD) offers home visiting, parenting training, infant stimulation and basic health care to families at risk of or previously investigated regarding child abuse and/or neglect. The Healthy Start Program follows the Hawaii Healthy Start and Prevent Child Abuse America's Healthy Families America model of home visitation. Healthy Start provides assessment and referral services for families as well as intensive home visiting services for families with an elevated risk of child abuse and/or neglect. The program targets adolescent and first time parents. The Help Us Grow Successfully Program (HUGS) provides home visits to pregnant women and families of children up through age 5. All of the home visiting programs offer the opportunity to educate and counsel families and make referrals for additional services, as well as provide parent support, child development information, health care information and general parent information. All home visitors are periodically trained on the signs, symptoms and mandatory reporting requirements for suspected child abuse. Children presenting to the local health departments for a variety of services including immunizations, WIC and EPSDT are assessed for needed services related to prevention of abuse and neglect.

During FY 2006-2007, the Department provided CHAD services in 22 counties with families being referred to this program by Child Protective Services. CHAD served 1,024 children from 694 families in FY 2007. The Healthy Start Program provided services in 27 counties, targeting first time parents who are in the prenatal period or who are at or near the time of birth. Healthy Start served 1,679 children in 1,465 families in FY 2007. HUGS provided services to 89 counties. HUGS revised its guidelines and home visiting orientation manuals as well as provided developmental tools training to home visiting staff.

Tennessee has a statewide network of 11 Child Care Resource and Referral Centers, each of which provides technical assistance, training, and resources to child care providers. These consultants receive training concerning child abuse prevention, recognition and reporting.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide home visiting services to pregnant women and families of infant and young children.		X		
2. Provide technical assistance, training and resources to child care providers through the network of Child Care Resource and Referral Centers.				X
3. Make referral for families accessing any type of health department programs and needing additional services.		X		
4. Implement the long term plan for Early Childhood Comprehensive System Planning grant.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHAD served 22 East and Northeast Tennessee counties in fiscal year 2007. Healthy Start serves 27 counties through its contract program. Healthy Start of Anderson County is not a contract program, but is a Healthy Start site. Anderson County provides service through a local initiative. New Healthy Start employees received the intensive initial training provided by Tennessee's national Healthy Families America trainer.

The CHAD and Healthy Start Program Director serves on the Child Abuse Prevention Advisory Committee. The Committee will make recommendations regarding the prevention system and oversees some prevention funding efforts. She was also invited to work with the Community Health Promotion section to assist with revision of the curriculum on Rape Prevention.

HUGS provided services to 89 counties. The program's goals include promotion of healthy growth and development and school readiness for all children.

The 11 Child Care Resource and Referral Centers continued to provide technical assistance, training, and resources to the over 5000 child care providers.

c. Plan for the Coming Year

All home visiting programs (CHAD, Healthy Start and HUGS) will continue to provide services. CHAD will serve 22 counties. The CHAD and Healthy Start Program Director will continue to work with the TN Prevention Advisory Committee to improve the child abuse and neglect prevention system in Tennessee. The Program Director will plan a Statewide Conference for Healthy Start Program Coordinators and Family Support Workers.

HUGS will continue to look at ways to provide home visiting services to the 6 Tennessee counties that lack such services. HUGS will automate and continue to standardize its programs. HUGS

will continue to provide staff training including a SIDS/grief counseling training and a training collaboration with Vanderbilt University (the MIND series). Early Childhood Comprehensive Systems (ECCS) will continue to host meetings to provide public and private agency professionals the chance to collaborate to improve child health and school readiness.

In FY 2008-09, parents will be added to the 11 Child Care Resource and Referral Centers. The role of the parents is to provide technical assistance, training, and resources to child care providers and other parents. They will promote the evidenced-based 5 Protective Factors for Families to prevent child abuse and neglect.

State Performance Measure 4: *Increase percentage of children with complete EPSDT annual examinations by 3 percent each year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	59	60	80	89	90
Annual Indicator	56.3	68.1	88.1	88.2	73.3
Numerator	440539	527845	663876	664879	597536
Denominator	782057	775232	753474	753982	814643
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	92	92	95	95	95

Notes - 2007
Data source is State of Tennessee TennCare

Notes - 2006
Data source is State of Tennessee TennCare

Notes - 2005
Data source is the State of Tennessee EPSDT data System

a. Last Year's Accomplishments
All 95 county health departments continue to provide EPSD&T screenings to TennCare-eligible children. In FY 2006-07, 58,276 screenings were done by the health departments. As previously reported, the Department of Health assumed the responsibility of screening children in the custody of the Department of Children's Services in June 2003. Data for 2006-07 from DCS show that 95% of children had been screened. The TENNderCare Community Outreach program, the TENNderCare Call Center and the TENNderCare Nursing Call Center raise awareness of the importance of EPSDT screening to parents of TennCare eligible children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide advocacy and outreach activities in all local health department clinics to TennCare enrollees, including information about the need for EPSDT.		X		
2. Provide EPSDT screening exams to TennCare enrollees in all local health departments clinics.	X			
3. Assist families with referrals to appointment for screening with primary care providers.		X		

4. Provide EPSDT screening exams for all children in custody of the Department of Children Services.		X		
5. Implement the EPSDT community outreach project.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Department of Health of Health operates three components to its outreach program to support the TENNder Care message, "Check In, Check Up, and Check Back." The Community Outreach Program is centered around community initiatives that promote awareness of the importnce of children receiving checkups covered by TennCare. The TENNderCare Call Center, located in Nashville has Call Center Operators on two shifts who provide individualized outreach to families of newly enrolled TennCare children and newly re-certified TennCare children. Parents are provided education on the importance of TENNderCare services and are advised that the costs of these services are provided by TennCare. With agreement of the parent, the Calll Center Operator will contact the member's primary care provider and make an appointment for the child and/or arrange transportation for the member. The Nursing Call Center provides telephone outreach to pregnant women covered by TennCare to discuss the importance of early contact and continuous prenatal care as well as the importance of the health screening for the baby.

c. Plan for the Coming Year

It is projected that as many as 65,000 EPSD&T screenings will be provided in a public health clinic in FY 09.

The TENNderCare Program will continue the three components of outreach. This should result in increased awareness to parents/guardians of TennCare eligible children about the importance EPSDT screenings and preventive care.

State Performance Measure 5: *Reduce the proportion of teens and young adults ages 15 to 24 with chlamydia trachomatis infections attending family planning clinics*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	5.2	5.2	5.2	5.2	5.2
Annual Indicator	6.7	6.6	6.9	6.3	6.5
Numerator	1589	1809	1985	1720	1578
Denominator	23685	27494	28890	27346	24334
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5.2	5.2	5.2	5.2	5.2

Notes - 2007

Data source is the Tennessee Department of Health.

Data source is the State of Tennessee STD infertility project data system

Notes - 2006

Data source is the State of Tennessee STD infertility project data system

Notes - 2005

Data source is the State of Tennessee STD infertility project data system

a. Last Year's Accomplishments
Chlamydia is one of the most common, treatable, sexually transmitted infections affecting women of reproductive age in the United States today. Chlamydia causes complications related to fertility and pregnancy, including increased rates of premature delivery, premature rupture of membranes and low birth weight. Tennessee, through family planning clinics and the sexually transmitted disease (STD) clinics, is providing screening and treatment statewide. The state is also participating in the Region IV Infertility Project funded through the Centers for Disease Control and Prevention. Approximately 120,000 tests are conducted annually. Both state appropriations and federal infertility project funds are available for the program.

In January 2003, the state Laboratory switched to the Aptima Combo 2, which has greatly increased the number of positive results for Chlamydia in all geographic areas, both rural and metropolitan. In 2004, the positivity rate for Chlamydia was 10.9%.

Data for calendar year 2007 showed a decrease in chlamydia cases with a positivity rate of 8.8% as compared to 10.9% for 2004. A total of 27,074 cases were reported in 2007. Of these cases, 72% were females and 87% occurred in patients ages 15-19. Rural regions had positivity rates ranging from 5-11%, and the metropolitan areas ranged for 7-16%.

In January 2004, the Department approved the use of directly observed therapy (DOT) by non-medical personnel (public health representatives/disease intervention specialists) using azithromycin for the treatment of chlamydia. This policy continues to provide an option for dealing with the most difficult patients and contacts.

Since 2004, staff began conducting risk assessments and offering chlamydia urine screening to adolescents being provided EPSDT screening exams in the local health department clinics. Screening was expanded to include the Knoxville juvenile detention center.

After analyzing the results from offering Chlamydia screening to women seeking "walk-in" pregnancy testing during Chlamydia Awareness Month, Tennessee began routinely offering Chlamydia testing to all women who requested a pregnancy test. Local health departments began offering this service on September 1, 2006. A comparison of the number of pregnant women tested during the first six months of 2006 (prior to implementation of the new policy) and the first six months of 2007 found a 400% increase in the number of tests offered. The positivity rate for African Americans was 13% and the rate for Whites was 5%.

As part of Chlamydia Awareness Month in April 2007, urine screening for gonorrhea and Chlamydia was offered on 7 college campuses statewide. An overall positivity rate of 11.6% was noted. As a result of these data, a state college has asked for resources to make this screening a routine medical service for students.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen for Chlamydia in family planning and sexually transmitted disease clinics in local health departments.	X			
2. Provide risk assessments and screening for adolescents as part of the EPSDT screening exam.	X			
3. Participate on the Region IV Infertility Project Advisory Committee.				X
4. Encourage use of directly observed therapy by non-medical personnel.	X			

5. Encourage use of partner delivered therapy.	X			
6. Participate in the Region IV Chlamydia Awareness Month.	X		X	
7. Provide information to the public through the Department's web site.			X	
8.				
9.				
10.				

b. Current Activities

Chlamydia screening is continuing in all family planning and sexually transmitted diseases clinics statewide. Chlamydia screening is also offered to women who request a "walk-in" pregnancy test. Representatives from all three programs (Family Planning, STD, and Laboratory) continue to participate on the Region VI infertility project advisory committee. Staffs continue to promote the use of partner delivered therapy in the clinics.

Other current year activities have included analyzing the project data from health department clinics by geographic area, by clinic type, and by age groups. Laboratory costs have greatly increased with the use of the amplified test, and several recommended options for changes to the screening criteria are being considered for implementation.

c. Plan for the Coming Year

Plans include continuing all the activities described in current activities, using urine-based testing in select youth detention facilities; using urine-based testing in appropriately targeted outreach screening initiatives; and pursuing directly observed therapy by non-medical staff for treating chlamydia.

The Department is planning initial discussions with state colleges to further examine the possibility of implementing routine gonorrhea and chlamydia screening for students. The Department will also begin planning for Chlamydia Awareness Month.

State Performance Measure 6: *Reduce the number of babies born prematurely.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				12	11
Annual Indicator			12.7	12.4	11.7
Numerator			10241	10454	10162
Denominator			80583	84277	86558
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	10	10	10	10	10

Notes - 2007

Data source is the Tennessee Department of Health.
Data source is the State of Tennessee provisional birth master files, Tennessee residents only.

Notes - 2006

Data source is Tennessee Birth master files, Tennessee resident only

Notes - 2005

State of Tennessee data source. (Health Statistics)

a. Last Year's Accomplishments
All local health department clinics offer basic prenatal care, which includes pregnancy testing presumptive eligibility determination for TennCare/Medicaid,WIC/nutrition services, counseling, information, and referrals to health care providers for medical care. The availability of these services in all counties increases the likelihood that pregnant women will enter into care early. HUGS continues to standardize his policies and procedures to be in a position to detrmine what parts are effective or not in improving birth outcomes. Women are also referred for home visiting services as appropriate (HUGS, Healthy Start, or CHAD). Pregnant women who smoke are offered counseling and education undr the Tobacco Use Prevention and Control Program. Under the managed care system in place under TennCare, most prenatal care is provided by private sector providers. Local health department clinics provide comprehensive prenatal care in 11 counties across the state for primarily Hispanic clients.

Data on WIC clients for May 2008 show that 21,900 pregnant women were participating in the program. If available in their county, the clients are assessed for the need for home visiting services and referred to the program. Currently, 81 counties provide home visiting services.

The state has five regional centers providing specialty care for high risk pregnant women and infants, as well as 24-hour consultation, transportation, professional education for providers, and technical assistance to facilities and providers. This system has been in place in the state since the 1970s and is well established and recognized. A Perinatal Advisory Committee (PAC) advises the Department on perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, perinatal transportation, and education objectives for perinatal nurses and social workers.

Other important services which can impact the health of women and play a role in lowering the overall prematurity rate are screening for sexually transmitted diseases and family planning. All local health department clinics offer screening for sexually transmitted diseases, including Chlamydia, Gonorrhea, Syphilis, and HIV, and family planning services, including education and counseling, physical exams, laboratory tests, and the birth control methods.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide pregnancy testing, counseling, and referral, and presumptive eligibility in all local health department clinics.	X	X		
2. Provide home visiting services for pregnant women.	X	X		
3. Provide comprehensive prenatal care in 10 counties.	X			
4. Provide WIC/nutrition services in all local heath department clinics.	X	X		
5. Continue the prenatal regionalization system.	X			X
6. Continue operating the toll free Baby Line and Live to 1 line.	X	X		
7. Coordinate with the Governor's Office of Children's Care Coordination on the new efforts to expand the availability of obstetrical services in targeted areas, establishment of FIMR teams, and other infant mortality reduction activities.	X			X
8.				
9.				

10.				

b. Current Activities
All programs and services described in the previous section continue to be available.
All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a physician for prenatal care and delivery. They are also enrolled in WIC or CSFP, the state's supplemental food and nutrition programs.

c. Plan for the Coming Year
The Department will to continue provide the services described above (perinatal regionalization, pregnancy testing, counseling, and referrals, WIC and nutrition services, home visiting services, prenatal care in selected counties, enrollment in TennCare under presumptive eligibility, TennCare outreach and advocacy, and S.M.A.R.T. Moms).

Local and regional health department will continue to assess the need for providing prenatal care within their clinics depending upon the availability of services within the private health care systems. All health department regional offices and local clinics will continue to implement various components of the Better Health: It's About Time initiative. The material on the 1 For All web site will be expanded to include new topics and information.

State Performance Measure 7: *Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis and Treatment(EPSDT) annual examinations by 5% each year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				50	50
Annual Indicator			10.3	9.7	39.4
Numerator			62000	58313	117570
Denominator			600000	600000	298233
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60	65	65	65	65

Notes - 2007
Data source is the State of Tennessee EPSDT data System and the Tennessee TennCare data. Data includes Children age 10-18 years and the data is based on FY 2005-2006

Notes - 2006
Data source is the State of Tennessee EPSDT data System and the Tennessee TennCare data.

Notes - 2005
Data source is the State of Tennessee EPSDT data System

a. Last Year's Accomplishments
Adolescents were targeted for outreach by the Community Outreach staff in all counties of the state, by the Managed Care Organizations, and by the TENNderCare Call Center which is located in the DOH Central Office in Nashville.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide advocacy and outreach activities in all local heath department clinics to TennCare enrollees, including information about the need for EPSDT.		X		
2. Provide advocacy and outreach activities in all local health department clinics to TennCare enrollees, including information about the need for EPSDT.	X			
3. Assist families with referrals to appointment for screening with primary care providers.		X		
4. Provide EPSDT screening exams for all children in custody of the Department of Children Services.		X		
5. Implement the EPSDT community outreach project.		X		
6. Implement the EPSDT community outreach education and screening project.		X		
7.				
8.				
9.				
10.				

b. Current Activities
Currently, all 13 regions of the state have community events that target teens at colleges, vocational schools, and in GED classes. Sporting events, health fairs and GED classess that educate teens on the importance of preventive health care.

c. Plan for the Coming Year
The community activities listed above will continue.
The TENNderCare call center operators will continuet to call the family of every newly certified and recertified adolescent on TennCare to inform them of the importance of the EPSD&T screening and to offer assistance with scheduling appointments and transportation assistance if needed.

State Performance Measure 8: *Reduce the number of pregnant women who smoke and or use illicit drugs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				10	10
Annual Indicator			10.7	10.4	10.1
Numerator			8749	8749	8721
Denominator			81454	84277	86558
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9	7	5	5	5

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2007 Tennessee Birth master files for this performance measure.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
Data source is Tennessee Health Statistics.
Currently Tennessee does not have PRAMS data collection but efforts is under way to start the PRAMS by year 2007.

a. Last Year's Accomplishments
Department of Health services delivery programs have been involved in smoking cessation programs for pregnant women for many years. Staff have also counseled pregnant women on the effects of alcohol and drug use. Whether working with pregnant women in WIC clinics, at a pregnancy test visit or enrollment in TennCare presumptive eligibility, or on home visits, staff have provided information, counseling, and support on the effects of smoking, alcohol, and drugs on the pregnant women and on the new baby. Referral information on the smoking Quit Line has been readily available in all local health department clinics fro years.

For four years, the March of Dimes funded a partnership between that agency, Middle Tennessee State University and the Department of Health to implement a smoking cessation program for pregnant women. Since the beginning, over 13,000 pregnant smokers in Tennessee received encouragement to quit or cut down on smoking using the "5-As" method of counseling (Ask, Assess, Advice, Assist, Arrange and use of a self help guidebook, either " A Pregnant Women's Guide to Quit Smoking" or "Need Help Putting Out That Cigarette?". The guidebooks include referral to smoking cessation quitline support especially for pregnant women.

Women are asked if they will accept the guidebook. On average, over ¾ of the pregnant women offered the guidebook agreed to take it. The data show that the pregnant smokers who received the guide were significantly more likely to quit smoking than those who did not receive the guide. In addition, for WIC mothers who delivered one baby, early prenatal care (1st trimester) and quitting smoking significantly reduced the chance of having a low birthweight infant. During 2005, the program was transitioned to the Department of Health, making it an integral ongoing component of WIC services.

The state's large WIC program targets pregnant women as the highest priority. Data for May 2006 show a caseload of 21,324 pregnant women (13.6% of the caseload). Local health department clinics performed 71,389 pregnancy tests during CY 2005, and enrolled 12,642 pregnant women in TennCare for presumptive eligibility during the same time period. All these visits provide opportunities to educate and counsel on smoking cessation and not using alcohol and drugs and to make appropriate referrals. The prenatal care guidelines and protocols for nurses provide guidance to staff on these topics.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide pregnancy testing, counseling, referrals, and presumptive eligibility for TennCare enrollment in all health department clinics.	X	X		
2. Provide WIC/nutrition services in all local health department clinics (all counties).	X	X		
3. Continue the activities of the TennCare/EPSDT Call Center staff related to calls to pregnant women and new mothers		X		
4. Provide home visiting services for pregnant women.		X		
5. Offer comprehensive prenatal care services, including counseling and education, in 10 counties.	X			

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b. Current Activities
Programs described above continue. All health department clinics offer walk-in pregnancy testing to the extent possible. The clinics maintain up-to-date referral mechanisms for assisting clients with positive pregnancy tests. In 2006, ten counties are offering full prenatal care services in health department clinics, predominately to non-TennCare eligible Hispanic clients, who are then delivered by private physicians. All clients qualifying from TennCare presumptive eligibility are provided with assistance in locating a local physician for prenatal care and delivery. They are enrolled in WIC or CSFP, the state's two supplemental food and nutrition programs. There are 137 WIC clinics statewide. Pregnant women are assessed for eligibility in one of the home visiting programs. All counties have home visiting services for pregnant women.

c. Plan for the Coming Year
The Department will continue to provide the services described above (pregnancy testing, counseling, and referrals, WIC and nutrition services, home visiting services, prenatal care in selected counties, enrollment in TennCare under presumptive eligibility, TennCare outreach and advocacy). All these services provide opportunities to counsel and educate pregnant women.

Staff at both the central office, regional, and local levels will continue to work with community partners on reducing infant mortality, low birth weight, and prematurity.

State Performance Measure 9: *Reduce the number of overweight and obese children and adolescents.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				30	30
Annual Indicator			31.9	31.9	39.9
Numerator			491	491	615
Denominator			1540	1540	1540
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	30	29	25	25	25

Notes - 2007
Data source is the Tennessee YRBSS conducted by Tennessee Department of Education 2005 Youth Behaviorial Risk Surveillance Survey (YRBSS) was used.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Data source is the State of Tennessee Youth Risk Behavior survey

Notes - 2005

2005 Tennessee Youth Risk Behavior Survey indicated that 31.9 % of school students were described as obese out of a total of 1,540 students surveyed.

a. Last Year's Accomplishments

Community nutrition staff worked to promote better health for various populations throughout the State of Tennessee. Major focus areas during the last year included obesity awareness/prevention, promoting healthful eating, breastfeeding promotion and counseling, and cultural competence. Our primary accomplishments in this area during the last year have focused on training and support to schools and various other agencies. We provide education and training as requested by school systems and professional groups on obesity risk. In 2006, the State of Tennessee passed House Bill number 445, which voluntarily allows schools statewide to measure BMI on all children and the report results to parents/guardians. To assist in the accurate measurement of BMI in schools in implementation of this bill, we created and distributed a training packet including a manual, training video, and reference guide. Approximately 50 training packet was distributed to public schools in Tennessee, and it is anticipated that the need for this training will continue to increase. In conjunction with this training, we have also purchased and distributed approximately 155 sets of BMI equipment including scales, stadiometers, easy reference guides (blood pressure cuffs and stethoscopes when requested) to school systems to promote accurate measurement of BMI. To promote knowledge and awareness of obesity in children in Tennessee, we participated in a training program for a total of ten schools participating in a pilot program funded by a grant from the Kellogg's Foundation. This program was designed to assist school systems in implementing wellness programs as required by federal public law 108-265. Training for these schools focused not only on how to accurately assess Body Mass Index, but also on how to identify and provide services to children at risk for obesity through helping to develop Wellness Plans and Policies mandated by USDA to be in effect July 2006. We have continued to serve as an active member of the Tennessee Healthy Weight Network (THWN), a statewide coalition involving representatives from departments of health and education as well as private industry and professional groups. This organization, which was created in 2002, works to promote healthful weight for all Tennesseans through proper nutrition, regular exercise, and other healthful habits. We work closely with the Tennessee Action for Healthy Kids Organization to help improve the nutrition and physical activity environment in schools throughout the state. Additionally, we continue to serve on the advisory committee for the Tennessee Department of Education Coordinated School Health Program to help promote the awareness, prevention, and treatment of obesity in schools. During the last fiscal year, staff also provide training for a variety of professional groups on obesity, complications of obesity, and the use of BMI.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, manage and analyze ESPDT screening data.	X			
2. Work with TennCare providers on Obesity prevention screening.	X		X	
3. Promote healthful eating through Tennessean WIC program.	X			
4. Coordinate with the school health program on activities related to overweight and obese children reduction.	X			
5. Provide education and training as requested by school system and professional groups on obesity and Body Mass Index (BMI).	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
As stated above, obesity awareness, prevention and treatment continues to be a major focus for community nutrition in our state. We continue to provide training as needed to schools, professional and employee organizations to promote awareness of obesity and related complications. We are currently working with the Tennessee Department of Education, Action for Healthy Kids, and the Tennessee Dietetic Association to assist schools in measuring and reporting BMI and in the implementation of required local wellness policies. We continue to distribute scales and stadiometers as needed to schools, and plan to reprint and distribute the BMI training packet during the next year.

c. Plan for the Coming Year
Community nutrition services in Tennessee will continue to collaborate with the Tennessee Action for Healthy Kids, and other coalitions and organizations as appropriate to improve the health of all Tennesseans. We plan to continue educational interventions to decrease obesity in our state, and will work to educate the public and motivate Tennesseans to improve health and wellness.

Within the next year, we will continue to work towards the goal of reducing the number of overweight and obese children and adolescents. We will work with educators and child advocates at the local regional, and state levels to promote programs that help improve health for all children. Through these efforts, we hope to continue to improve the health of individuals, families, and communities throughout Tennessee.

State Performance Measure 10: *Increase the percentage of youth with special health care needs, age 14 and older, who receive formal plans for transition to adulthood.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				100	100
Annual Indicator			100.0	100.0	100.0
Numerator			1234	1234	1534
Denominator			1234	1234	1534
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Data source is the State of Tennessee CSS data system

Notes - 2006
Data source is the State of Tennessee CSS data system

Notes - 2005
Data source is the State of Tennessee CSS data system

a. Last Year's Accomplishments
CSS is in the process of conducting training for all CSS program staff. CSS has identified national transitional partners to conduct this training. Following this training, CSS will create a statewide transitional plan that will be used as a model for all individual transition plans. CSS has ordered the 411 on Disability Disclosure Workbook for Youth with Disabilities to be distributed to all youth aged 14 and older.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, manage and analyze data on the transitional plans of adolescent to adult services.				X
2. Continue education of providers, families and citizens.				X
3. Access Community Resources toward transition to adulthood.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS is working at identifying each need a child and family will have concerning transition from adolescence to adulthood. CSS is developing a statewide transitional team as well as regional transitional teams and is identifying available as well as non-available transitional resources within the community. A resource guide to transitions has been developed that will be shared with all other agencies, private providers, advocacy groups, families, and any other entity interested in transitions to adulthood. CSS staff will continue to hold transitional training meetings across the state.

c. Plan for the Coming Year

CSS is in the process of developing a statewide transitional team and plans that can be utilized in regional and metro areas. The team will be comprised of parents of children with special health care needs, CSS participants, staff and community agency representatives. A statewide meeting has been planned for June 2008 to standardize and enhance transitional services to the CSS participants. Field staff will be provided technical assistance by Healthy Ready to Work. Age appropriate transitional plans will be developed for all participants age 14 and older.

E. Health Status Indicators

The MCH section operates two hotlines. Two are staffed by the MCH and Womens Health sections. The Baby Line, a toll-free telephone line, answers questions, refers callers for pregnancy testing, TennCare and prenatal care within the area where they live, and responds to requests for printed material. The goal is to get women into care during the first trimester of pregnancy. Patient information is provided to TennCare high risk pregnant women. Over 40 health education materials are available for distribution.

The Clearinghouse for Information on Adolescent Pregnancy Issues is a separate, central, toll-free telephone for professionals and parents seeking information on local resources, teen pregnancy statistics, resource materials, information on adolescent issues, and services. Professional staff of the agency respond to questions and concerns. Questions concern family planning and pregnancy information, medical information and relationship issues confronting the teen caller. Factual information and referral are provided as appropriate.

MCH has four advisory committees: Perinatal Advisory Committee for the Perinatal Regionalization Program; Genetics Advisory Committee for the Newborn Metabolic Screening

and the Newborn Hearing Screening Programs; the Children's Special Services Advisory Committee; and the Women's Health Advisory Committee.

Quality Management System: The quality units at the local level are empowered to resolve problems whenever possible in addition to streamlining existing services. The State Quality Council meets twice yearly to review reports on QM activities, including aggregated trends and recommendations from quality units and quality teams. The Directors of MCH and Women's Health/Genetics serve on the State Quality Council. The statewide Quality Management Plan developed by the Bureau of Health Services is updated yearly. The quality management process, including record review and follow up, is conducted statewide to assure an optimum level of services for all clients. Clinic-specific patient satisfaction surveys, in English and Spanish, are conducted for one week of every year in all rural clinics.

Additional information related to II. E. State Agency Coordination:

Adolescent Health Program --

Youth health guides were purchased for Tennessee and had being distributed in partnership with the Departments of Education, Mental Health and Developmental Disabilities, Children's Services, and Human Services. The guides have been shared with faith groups, wellness teachers and school nurses as well as Department of Children's Services case managers. The booklet will updated again in 2008 with information specific to Tennessee. In addition, a new health guide, Tennessee's Asthma Guide will be available in the fall of 2008. Public health nurses from each of the 13 regions throughout the state continue to collaborate with the Adolescent Health Program and address special interest and expertise in adolescent healthcare.

The Tennessee Adolescent and Young Adult Health Program website will continue to be updated with latest statistics as they become available. Also, the Adolescent Health Leadership committee will continue to meet and discuss best practices for Tennessee's youth in accordance with Healthy People 2010 Goals and Healthy People 2020 when goals become available.

F. Other Program Activities

IV. PRIORITIES, PERFORMANCE AND ACTIVITIES

The MCH section operates two hotlines. Two are staffed by the MCH and Womens Health sections. The Baby Line, a toll-free telephone line, answers questions, refers callers for pregnancy testing, TennCare and prenatal care within the area where they live, and responds to requests for printed material. The goal is to get women into care during the first trimester of pregnancy. Patient information is provided to TennCare high risk pregnant women. Over 40 health education materials are available for distribution.

The Clearinghouse for Information on Adolescent Pregnancy Issues is a separate, central, toll-free telephone for professionals and parents seeking information on local resources, teen pregnancy statistics, resource materials, information on adolescent issues, and services. Professional staff of the agency respond to questions and concerns. Questions concern family planning and pregnancy information, medical information and relationship issues confronting the teen caller. Factual information and referral are provided as appropriate.

Call GWEN is a statewide teen hotline contracted to United Neighborhood Health Services, which operates primary care centers in Nashville. The agency runs programs that provide counseling services for pregnant and parenting teens. Professional staff of the agency respond to questions and concerns. Questions concern family planning and pregnancy information, medical information and relationship issues confronting the teen caller. Factual information and referral are provided as appropriate.

MCH has four advisory committees: Perinatal Advisory Committee for the Perinatal Regionalization Program; Genetics Advisory Committee for the Newborn Metabolic Screening and the Newborn Hearing Screening Programs; the Children's Special Services Advisory Committee; and the Women's Health Advisory Committee.

Quality Management System: The quality units at the local level are empowered to resolve problems whenever possible in addition to streamlining existing services. The State Quality Council meets twice yearly to review reports on QM activities, including aggregated trends and recommendations from quality units and quality teams. The Directors of MCH and Women's Health/Genetics serve on the State Quality Council. The statewide Quality Management Plan developed by the Bureau of Health Services is updated yearly. The quality management process, including record review and follow up, is conducted statewide to assure an optimum level of services for all clients. Clinic-specific patient satisfaction surveys, in English and Spanish, are conducted for one week of every year in all rural clinics.

Additional information related to II. E. State Agency Coordination:

Adolescent Health Program --

Adolescent health surveys from both public and private providers of adolescent health care were collected and analyzed. The results of these surveys along with secondary data will be incorporated into the States first ever adolescent health data report. This report was distributed in Fall 2006.

In addition, adolescent health representatives, public health nurses, from each of the 13 regions throughout the state continue to meet and distribute information and technical assistance on the promotion of adolescent health. In January 2006, they met and determined ten priority areas for adolescent health in Tennessee.

G. Technical Assistance

Technical assistance was requested for the new CSS Program Director. The director will be participating in the new mentor program. CSS also requested technical assistance from the Healthy Ready to Work program for transition of adolescence to adulthood.

V. Budget Narrative

A. Expenditures

The budget for Maternal and Child Health for FY 2008 remains basically the same as in the previous fiscal year. The required targeting percentages for preventive and primary care for children (30%), children with special health care needs (30%) and administrative costs for Title V (10%) have been met. Other funding sources in support of Maternal and Child Health Programs include state funding for match and maintenance of effort, earned current services revenue, inter-departmental revenue and funding from federal grants; Title X, SSDI, Newborn Hearing Screening, Early Comprehensive Childhood Systems.

Tennessee maximizes all other funding sources such as earned current services revenue, and budgeted state appropriation before Title V funding is used to fund authorized expenditures generated by Maternal and Child Health Program activities. Maternal and Child Health funding is used to support program management and oversight in the Central Office, funding support for local and metropolitan health departments and funding support for contract agencies that fill gaps in services or provide unique services to specific populations. Maternal and Child Health contracts with agencies to provide genetics and newborn screening services, services for children with special health care needs, home visiting services and family planning. Detailed budget documentation is maintained in the Bureau of Health Services, Fiscal Services Section and is available for review as needed.

The Bureau of Administrative Services (BAS) within the Department of Health is responsible for all fiscal management. BAS uses the State of Tennessee's Acoounting and Reporting system (STARS) for budgeting, collection of revenues and distribution of expenditures by allotment code and program cost center. Computer generated cumulative expenditure and receipt plan analysis, transaction listings and spending receipt plan is available statewide on-line for all MCH programs and can be accessed by both central and regional office staff. Financial audits are the responsibility of the Comptroller's Office. All departments, offices and programs within state government are subject to frequent audits. Contract agencies are also audited frequently. MCH program staff provide site visits and program monitoring at contract agencies in order to assure compliance with the contract's scope of services. Fiscal monitoring of contract agencies is the responsibility of the Department of Health's Internal Audit staff.

Maternal and Child Health Programs are organizationally aligned to the Bureau of Health Services, Tennessee Department of Health. The Bureau of Health Services has developed detailed policies and procedures for use by local health departments, metropolitan health departments, regional public health offices and central office staff involved with budgeting of funds, collection of revenues, depositing revenues, accounts receivable, aging of accounts, charging patients and third parties, petty cash, posting receipts and contracting for services. Bureau of Health Services policies and procedures are available to all sites and are posted on the Department's Intra-Net for easy references. All policies and procedures have been developed in accordance with applicable state law and rules of the Department of Finance and Administration.

B. Budget

Tennessee state law requires all departments to submit a complete financial plan, base budget request, for the ensuing fiscal year that outlines proposed expenditures for the administration, operation and maintenance of programs. Budget guidelines are prepared annually by the Department of Finance and Administration. The Bureau of Health Services Fiscal Services Section, in cooperation with all programs, is responsible for the preparation of the budget documents. The base budget request becomes law after it is approved by the General Assembly and signed by the Governor. A work program budget is then developed for each cost center and

program.

The Department of Health uses a cost allocation system for local health departments. Costs are allocated using two specific methods, the direct cost allocation method and the resource based relative value method (RBRVS). The direct cost allocation method is used when costs can be directly allocated to one or more programs. Any cost can be directly allocated when coded correctly on the appropriate accounting document. Direct cost allocation is used primarily for costs that arise from administrative support staff in the Bureau of Health Services central and regional offices and for selected contract expenditures. The RBRVS cost allocation method is used to allocate costs which cannot be directly allocated to one or more programs. These costs arise from the delivery of direct health or patients care services delivered in rural health departments. RBRVS adds weighted encounter activities using relative value units and allocates costs based on the percentage of activity for each program. RBRVS is a federally approved cost allocation method for the Tennessee Department of Health. RBRVS is fully automated with computer linkage at the service delivery level to AS 400 computers at the regional and central offices.

Program encounter data is entered at local health departments for direct patient care services using CPT procedure and program codes. Relative value units assigned to each procedure code allows a proportionate amount of cost to be associated with each procedure. RBRVS provides monthly cost allocation reports to central and regional office staff. These reports are used to monitor expenditures, determine cost for services provided, and allocate resources as needed.

The maintenance of effort for the Maternal and Child Health Block Grant was established in 1989 in accordance with requirements of the block grant. The maintenance of effort, $13,125,024.28, was established through an analysis of 15 months of expenditures for Maternal and Child Health Programs, adjusted for differences between the state and federal fiscal years, as well as, adjustments for accrued liabilities. The Tennessee Department of Health and the Bureau of Health Services fully supports using state funds to meet the maintenance of effort and match requirements in support of Maternal and Child Health Program activities.

Tennessee fully utilizes Maternal and Child Health Block Grant funding within the 24 month allowable timeframe and meets all targeting, maintenance and match requirements set forth in the block grant regulations. Any carry forward noted in the annual report will be used to support or expand Maternal and Child Health activities. Carry forward funding has been used to develop new services or to expand current programs. During these recent years carry forward funding has been used to improve dental and other health care screening services, provide preventive fluoride varnish for children seen in health department clinics, funded increased program activity relative to infant mortality, teen pregnancy prevention and enhance breast and cervical screening for reproductive age women. Funding was increased for home visiting services for pregnant women and families with high risk infants and young children and care coordination services for families with children with special health care needs.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.